

NAVIGATION GUIDE TO LONG TERM CARE INSURANCE

A Quick Reference Guide for
SHIP Counseling

The Navigation Guide for Long term Care Insurance is designed for use during telephone or face-to-face counseling.

All information is presented in the second-person format, using **you** in place of he/she, the person, the beneficiary, etc.

For more detailed information or if you have questions, please contact the SHIP Training Officer at:

1-800-452-4800, extension 224

REFERENCE MATERIALS

SECTION 1

Reference Materials

- **Shopping Tips When Buying Long Term Care Insurance**
- **Traditional and Indiana Long Term Care Partnership Program Policies**
- **Long Term Care Insurance In Indiana - Company Listing**
- **Partnership Policies in Indiana - Company Listing**
- **Consumer Information Bulletin
(LTC Policy Tax Information)**

Shopping Tips When Buying Long Term Care Insurance

- **Contact SHIP, the State Health Insurance Assistance Program**

They can provide you with guidelines and a Long Term Care Self Assessment Guide. A list of insurance departments and counseling programs in the U.S. begins on page 20 of your "Shoppers Guide."

- **Check with several companies and agents**

It is wise to contact several companies and agents before you buy a policy. Be sure to compare benefits, the types of facilities you have to be in to receive coverage, the limitations of coverage, the exclusions, and, of course, the premiums. (Policies that provide identical coverage and benefits may not necessarily cost the same.)

- **Take your time and compare Outlines of Coverage**

Never let anyone pressure or scare you into making a quick decision. Don't buy a policy the first time an agent comes calling. Ask the agent to give you an "Outline of Coverage". The Outline of Coverage summarizes the policy's benefits and highlights important features. Compare Outlines of Coverage for several policies.

- **Understand the policies**

Make sure you know and understand what is covered by a policy. If you have any questions, ask the agent, or call the insurance company's home office, before you buy. If an agent gives you answers that are vague or differ from information in the company literature, or if you have doubts about the policy, tell the agent you will get back them later.

Don't hesitate to call or write to a company and ask your questions. **Beware of an agent who claims the policy can be offered only once.**

Some companies may sell their policies through the mail, bypassing agents entirely. If you decide to buy a policy through the mail, and you don't understand how the policy works, call or write to the company.

- **Discuss the policy with a friend or relative.**
- **Don't be misled by advertising.**

Most celebrity endorsers are professional actors paid to advertise. They are not insurance experts.

Neither Medicare nor any other federal agency endorses or sells long-term care insurance policies. Be wary of any advertising that suggests the federal government is involved.

Don't trust cards you get in the mail that look as if the federal government sent them. Insurance companies or agents trying to find buyers may have sent them. Be careful if anyone asks you questions over the telephone about Medicare or your insurance. They may sell any information you give to long term care insurance marketers, who might call you, come to your home, or try to sell you insurance by mail.

- **Don't buy more than one long-term care insurance policy.**

You don't have to buy more than one policy to get enough coverage. One good policy is enough.

- **Don't be misled by long-term care insurance marketers who say your medical history isn't important.**

Information about your medical history is very important. Be sure you fill out all of the application. Give correct information. If an agent fills out the application for you, don't sign it until you have read it. Make sure that all of the medical information is right. If it isn't and the company used that information to decide whether to insure you, it can refuse to pay your claims and can even cancel your policy.

- **Never pay in cash.**

Use a check or money order made payable to the insurance company

- **Automatic Premium Withdrawal**

Think about having the premium automatically taken out of your bank account. Automatic withdrawal may mean that you won't lose your coverage if an illness makes you forget to pay your premium. **If you decide not to renew your policy, be sure you tell the bank to stop the automatic withdrawals.**

- **Be sure to get the name, address, and telephone number of the agent and the company.**

Get a local or toll-free number for both the agent and the company.

- **Check on the financial stability of the company you are considering**

Several private companies rate insurance companies based upon their own research and from published data. These ratings offer an idea of the financial health of a rated company, however; there are no guarantees of accuracy attached to these ratings. Different agencies use different rating scales, so it is important to know what each agency's scale means.

Ratings and rating agency information is available from most public and university libraries, or you can contact the agencies directly by telephone or by website. (Note, there is an extra charge for calls to a "900" number.)

Some widely used companies that offer ratings include:

- **A. M. Best Co.** (900) 555-BEST-to charge to phone bill
(800) 555-BEST -to use credit card
(a charge per call,
& per each rating)
- **Duff U Phelps, Inc.** (312) 368-3157 One free rating
- **Fitch Investors Service, Inc.** (212) 908-0500
- **Moody's Investor Service** (212) 553-0377 Up to 3 free ratings
- **Standard & Poor's** (212) 208-1527 Up to 5 free ratings
- **Weiss research, Inc.** (800) 289-9222 Charge for Verbal ratings.
- **Telephone the Indiana Department of Insurance (IDOI) Consumer Service Division**
For information on a company's licensing, or if you have question about the agent, the insurance company, or the

- **If you don't get your policy within 60 days, contact the company or agent.**

You have a right to expect prompt delivery of your policy.

When you do receive your policy, check to see if you need to sign and return any forms. **Be sure to keep the envelope** the policy was mailed in, or if the agent delivers it personally ask the agent for a signed delivery receipt as proof of the date you received the policy. Make and keep copies of any forms that you are asked to complete and return.

Keep your policy in a convenient place where you can easily find it. Tell a trusted friend or relative where it is located.

- **Be sure you look at your policy during the 30 day free-look period.**

Read the policy again. Make sure it gives you the coverage you want, and that the benefits are what you expected. If you have any questions, call the agent or company right away.

Also, re-read the application that you signed. It is part of the policy. If it's not filled out correctly, contact the agent or insurance company right away.

You have 30 days, starting from the day that you receive the policy, to return it for any reason for a full refund (**you do not have to give a reason**, but be prepared for the company to ask).

- If you want to cancel your policy, do the following:
 - Make a copy of the original envelope in which the policy was mailed, or if it was delivered, make a copy of the hand-delivered receipt.
 - Send the policy to the insurance company along with a **short letter asking for a refund**, a copy of the original mailing envelope or the hand delivered receipt, and copies of any forms that you completed.
 - Send your request certified mail. **Keep the mailing receipt.**
 - Keep a copy of all letters from the company to you, and from you to the company. **It usually takes four to six weeks to get your refund.**

FEATURES	TRADITIONAL LONG TERM CARE INSURANCE POLICIES (LTC)	INDIANA LONG TERM CARE PARTNERSHIP PROGRAM POLICIES (ILTCIP)
<u>Agent Training</u>	Agents must have (a) a health insurance license; (b) 8 hours of continuing education (C.E.) in LTC to begin selling LTC insurance; (c) 5 additional hours of C.E. in LTC every 2 years.	Agents must meet all of the requirements for selling traditional LTC policies PLUS must complete a one time only 7-hour course on the ILTCIP before ever selling or talking about these policies.
<u>Asset Protection</u>	These policies do <i>not</i> provide permanent asset protection.	Policies provide permanent asset protection through the <i>State-added</i> benefit known as "Medicaid Asset Protection."
<u>Benefit Triggers</u>	The <i>company</i> decides which benefit triggers (what has to occur before the policy starts paying benefits) to use and how to define the terms within the triggers.	The <i>State</i> determines which benefit triggers that all participating companies must use and how to define the terms within the triggers.
<u>Daily Benefits</u>	Can buy any amount of daily benefit the insurance company chooses to offer.	Can buy any amount of daily benefit the insurance company offers. A company must offer a minimum daily benefit of \$110/day (<i>state-determined for 2006</i>).
<u>Inflation Protection</u>	Inflation protection must be OFFERED.	Inflation protection must be INCLUDED. (Companies are using 5% compounded interest annually.)
<u>Maximum Benefits</u>	<i>Company</i> decides how the maximum benefit will be offered - in days, in dollars, one pool of money for all benefits, or separate maximum benefits for nursing home and home health care. Can buy any amount of maximum benefits the company offers.	<i>State</i> decided that maximum benefit would be one pool of money for all benefits available in the policy. Can buy any amount of maximum benefits the company offers. However, the company must offer the option of purchasing a maximum benefit equal to one year of nursing home coverage.

<u>Portability</u>	The policy will pay benefits in any state.	The policy will pay insurance benefits in any state. However, the State-added benefit of Medicaid Asset Protection can only be honored by Indiana's Medicaid program*. This means the person must be in Indiana when applying for and while receiving Indiana Medicaid assistance. (*Due to a reciprocal agreement between IN and CT, Connecticut's Medicaid program can also honor the asset protection earned in a Partnership policy. Asset protection honored under a reciprocal agreement is on a dollar-for-dollar basis only.)
<u>Tax Deductions for Premiums</u>	*Tax-Qualified policies are available for federal tax deduction. There is NO state tax deduction for traditional LTC policies.	*Tax-Qualified policies are available for federal tax deduction. Premiums paid for an LTCIP policy qualify for an Indiana state tax deduction beginning with tax year 2000.
<u>Types of Policies</u>	Can buy policies covering: nursing home care only nursing home & home health care home health care only life insurance that will pay a portion of the death benefit early for LTC.	Can buy policies covering: nursing home care only nursing home and home health care All participating companies must offer policy type (b).

***Tax-Qualified LTC Policies:** Premiums (up to certain limits) may be deducted on a federal tax return AS PART OF the standard medical expense deduction. The benefits received from (federally) Tax-Qualified LTC policies will *not* be considered taxable income. Federal law requires Tax-Qualified policies to offer the option of purchasing a non-forfeiture benefit (a guarantee of some amount of benefit should the policyholder cancel the policy after owning it for a minimum number of years). This law also provides some guidance to the companies in determining the benefit triggers to use in their policies. "Medical Necessity" cannot be used as a benefit trigger in Tax-Qualified policies.

Note: Indiana Law and Insurance Regulation require ALL types of long term care insurance policies in Indiana to offer a 30-day free look, prohibit the requirement of prior hospitalization in order to receive benefits in policies sold after July 1991, prohibit waiting periods of longer than 6 months for pre-existing conditions, and require policies to be either guaranteed renewable or noncancellable.

Long Term Care Insurance In Indiana

The following companies have been approved by the
Department of Insurance to sell individual Long Term Care insurance

Company Name	LTC #	LTC Claim #
Aetna Life	(800) 537-8521	(800) 248-0591
Aid Association (Lutherans only)	(800) 225-5225	(800) 225-5225
AIG Life	(800) 710-9876	(800) 710-9876
Allianz Life	(800) 814-8841	(800) 814-8841
American Family Life (AFLAC)	(800) 992-3522	(800) 992-3522
American Family Mutual	(800) 333-6886	(800) 333-6886
American Fidelity	(888) 412-2121	(800) 780-3724
American United Life	(800) 863-9354	(800) 863-9354
Bankers Life & Casualty	(888) 282-8252	(800) 621-3724
Bankers United Life	(800) 842-7799	(800) 432-0059
Catholic Order of Foresters	(800) 552-0145	(800) 552-0145
Central States Health & Life	(800) 541-2363	(800) 643-5264
Combined Insurance	(800) 999-2170	(800) 999-2170
Continental Life	(800) 264-4000	(800) 264-4000
CUNA Mutual Life	(800) 356-6006	(800) 643-5264
Farmers New World Life	(206) 232-8400	(800) 262-6995
First Penn-Pacific Life	(800) 323-1746	(800) 323-1746
Fortis Long Term Care	(800) 377-7311	(800) 377-7311
General Electric Capital	(800) 456-7766	(800) 876-4582
Genesis	(800) 838-0080 Ext 224	(800) 838-0080 Ext 224

Company Name	LTC #	LTC Claim #
Golden Rule	(800) 265-7791	(800) 265-7791
	Ext 2008	Ext 2008
Great American Life	(800) 771-2142	(800) 921-9338
Hartford Life	(800) 921-9345	(800) 921-9345
IDS Life	(800) 862-7919	(800) 862-7919
John Alden Life	(888) 503-8104	(888) 503-8104
John Hancock Mutual Life	(800) 543-6415	(800) 543-6415
Kanawaha	(800) 635-4252	(800) 635-4252
Knights of Columbus	(800) 380-9995	(800) 214-9825
Life & Health	(800) 458-7493	(800) 458-7493
LifeUSA	(800) 814-8841	(800) 814-8841
Lincoln Benefit Life	(877) 525-4582	(888) 503-8110
Lutheran Brotherhood	(800) 990-6290	(800) 990-6290
MedAmerica	(800) 544-0327	(800) 544-0327
Medico Life	(800) 228-6080	(800) 228-6080
Metropolitan Life (AARP members only)	(800) 308-0179	(888) 687-0977
Mutual Protective	(800) 228-6080	(800) 228-6080
National States	(800) 868-6788	(800) 868-6788
New York Life	(800) 224-4582	(800) 224-4582
Northwestern LTC	(877) 582-6582	(800) 890-6704
Penn Treaty	(800) 362-0700	(800) 222-3469
Pennsylvania Life	(800) 275-7366	(800) 636-4357
PFL Life	(800) 338-0257	(800) 432-0059

Company Name	LTC #	LTC Claim #
Physicians Mutual	(800) 228-9100	(800) 228-9100
Pyramid Life	(800) 777-1126 Ext 307	(800) 444-0321
Southwestern Life	(800) 792-4368 Ext 7443	(888) 304-9200
Standard Life	(888) 290-1085	(888) 350-1488
State Farm	(888) 827-2748	(888) 827-2748
State Life	(317)285-2326	(888) 505-8101
Teachers Insurance	(800) 223-1200	(800) 842-2733 . Ext 7307
Trustmark	(888) 249-6985	(800) 554-1640
United America	(972) 529-5085	(972) 529-5085
United Teacher Assoc. Insurance Co.	(800) 258-7041	(800) 258-7041
UNUM Life	(800) 543-7612	(800) 693-4988

Companies with Indiana Partnership Long Term Care Policies (12/2009)

INSURANCE COMPANY	*POLICY TYPES	AM BEST ¹	MOODY'S ¹	STANDARD & POOR'S ¹
Bankers Life and Casualty Company 1-888-282-8252	3,4	B	Baa3	BB-
Genworth Life Insurance Company 1-800-456-7766	3,4	A	A1	A
John Hancock Life Insurance Company 1-800-377-7311	3	A++	Aa1	AA+
Massachusetts Mutual Insurance Company 1-800-272-2216	3,4	A++	Aa1	AAA
Metropolitan Life Insurance Company 1-800-308-0179	3,4	A+	Aa2	AA-
The Prudential Insurance Company of America 1-800-732-0416	3	A+	Aa3	AA-
State Farm Mutual Automobile Insurance Company 1-866-855-1212	3	A++	Not Rated	AA
United Teachers Associates Insurance Company 1-800-258-7041	3	A-	Not Rated	Not Rated

* (1) Comprehensive policy - covers both nursing home and home care.

(3) Tax-Qualified Comprehensive policy - eligible for federal tax deduction. (2) LTC Facility policy - covers care only in a facility such as a nursing home.

(4) Tax-qualified LTC Facility policy - eligible for federal tax deduction.

¹Financial Stability Ratings – Explanation of ratings on reverse side. Experience shows the best resource for specific policy information is your local certified Indiana Partnership agent.

To obtain a free copy of the *Indiana Partnership Select Agent Directory*, call 317-233-1470.

Rating Scales And Definitions

A.M. Best Company

A++	Superior
A+	
A	Excellent
A-	
B++	Very Good
B+	
B	Fair
B-	
C++	Marginal
C+	
C	Weak
C-	
D	Poor
E	Under State Supervision
F	In Liquidation
S	Rating Suspended

Rating Modifiers

g	Group
p	Pooled
v	Reinsurance
u	Under Review

Moody's Investment Service

Aaa	Exceptional
Aa	Excellent
A	Good
Baa	Adequate
Ba	Questionable
B	Poor
Caa	Very Poor
Ca	Extremely Poor
C	Lowest

Modifiers:

- 1 = High end generic category
- 2 = Middle of generic category
- 3 = Low end generic category

Standard & Poor's

Secure Range:

AAA	Superior
AA	Excellent
A	Good
BBB	Adequate

Vulnerable Range:

BB	May be adequate, but vulnerable
B	Vulnerable
CCC	Extremely Vulnerable
R	Regulatory Action
pi	Rating based on public information only

Modifiers:

Plus (+) or Minus (-): Relative standing within major rating category.

Since company ratings can change, you are encouraged to check your local public libraries or the internet for the most current ratings. (Information 2004)



CONSUMER INFORMATION BULLETIN

Tax Breaks for Owners of Certain Long Term Care Insurance Policies

STATE Indiana residents who pay premiums for *Indiana Partnership long term care insurance policies* can receive a *state tax deduction*, beginning with tax year 2000. A taxpayer may take this deduction only for premiums paid (during the tax year) for an Indiana Partnership policy for himself/herself, a spouse, or both taxpayer and spouse.

How do I know if I have an Indiana Partnership Policy?

To know if the policy you own is an Indiana Partnership policy, look for the following box of information on the outline of coverage, the application, or the front page of the policy:

This policy qualifies under the Indiana Long Term Care Program for Medicaid Asset Protection. This policy may provide benefits in excess of the asset protection provided in the Indiana Long Term Care Program.

FEDERAL The Health Insurance Portability and Accountability Act of 1996 is a federal law providing limited federal tax breaks for owners of long term care (LTC) insurance policies that meet specific standards. Policies meeting these standards are called tax-qualified. The Act went into effect on January 1, 1997. It allows all LTC insurance policies bought before January 1, 1997, to qualify as tax-qualified.

What tax breaks does this federal tax law provide?

- (1) **Premiums:** Premiums paid for federally tax-qualified LTC insurance policies are tax deductible as part of the standard deduction for medical expenses on a federal tax return. This deduction applies for each taxpayer who pays premiums, and began with the 1997 tax year. These deductions are limited according to the age of the taxpayer as indicated below (amounts listed are for tax year 2009 based on your age as of December 31, 2009, and change annually for inflation):

<u>Age</u>	<u>Maximum Amount of Premium Deduction</u>
40 or less	\$ 320
41 to 50	\$ 600
51 to 60	\$ 1,190
61 to 70	\$ 3,180
71 and over	\$ 3,980

- turn over -

Premiums for self-employed: For self-employed persons, for tax year 2009, 100% of premiums paid for federally tax-qualified LTC insurance policies are tax deductible in a similar manner as other health insurance policy premiums. This deduction is limited according to the age table listed previously.

Benefits: Benefits received from a federally tax-qualified LTC insurance policy are not considered income for tax purposes. (The federal government has not yet determined whether benefits from a “non-tax-qualified” policy would count as taxable income.)

How do I know if a policy is a federally tax-qualified LTC insurance policy?

Look for language on the outline of coverage and on the policy that is similar to the following:

"This Policy is intended to be a Qualified Long Term Care Insurance Contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended."

What are some of the features included in federally tax-qualified LTC policies?

- (1) **Benefit Triggers:** A benefit trigger is the event that must occur in order for the policy to begin paying out its benefits. The policyholder must meet the criteria of one of the benefit triggers. Federally tax-qualified policies will contain the following benefit triggers: (a) needing substantial assistance with at least 2 of 5 (or 6) activities of daily living, and (b) needing substantial supervision due to a severe cognitive impairment. A licensed health care practitioner must certify that the triggering condition exists and, to the best of their knowledge, will continue to exist for the next 90 days. (Activities of daily living may include bathing, continence, dressing, eating, toileting, and transferring.)
- (2) **Nonforfeiture Benefit:** The applicant must be offered the chance to purchase a nonforfeiture benefit as part of their policy. A nonforfeiture benefit is a guarantee from the company that you will get some of the benefits in the policy you have bought, should you cancel the policy after a set period of time. This benefit increases the policy's price.

Required Consumer Protection Standards:

To get benefits from the policy, they cannot require you to be in the hospital first.

To keep up with rising costs in health care, an inflation protection benefit must be offered to you.

The policy must be guaranteed renewable. This means the policy will continue as long as you keep paying the premium. Your premium cannot be raised because you get older or have used some of the benefits in your policy.

For More Information

For a free packet of information on traditional LTC insurance policies and Indiana Partnership policies, call 1-800-452-4800.

For a free copy of the *Indiana Partnership Select Agent Directory*, call 317-233-1470; or, visit www.longtermcareinsurance.IN.gov.

**LONG TERM
CARE**

SECTION 2

LONG TERM CARE (LTC)

A Brief Look at Long Term Care Insurance

LTC is the largest national catastrophic health expense. As more people live longer, the need for health care and long term care increases as is illustrated by the following information.

- Of those individuals who turned age 65 this year, 60% will need long term care as they grow older. Almost 43% will enter a nursing home at some point in their lives for varying lengths of stay. Women are at higher risk than men, with slightly more than half entering a nursing home at some point in their lives.
- Nearly 5% of the elderly are in a nursing home.
- Approximately 85% of nursing home residents are women.
- Over 40% of Americans receiving long term care are under age 65.
- Ten percent of nursing home patients are under age 65.
- Of those who enter a nursing home, 55% will need care for at least one year, and one in five will need care for five or more years.
- The average cost of nursing home care in Indiana is more than \$60,000 per year. With an average length of stay of 2.5 years, the average cost for a nursing home stay is more than \$150,000.
- Medicare pays less than 10% of nursing home costs.
- Over 2,100 employers offer group long term care insurance.
- Approximately one-half of all nursing home care is paid for by Medicaid, and another one-third is paid for by individuals directly out of pocket.
- The most frequently cited reason for purchasing long term care insurance is to maintain independence and choice.

Levels of Long Term Care

Should you need LTC due to a prolonged illness, disability, or frailty service may be provided in your home or in a nursing home (NH). Your physician and your physical condition will determine whether you need:

- **Skilled Nursing Care** - Skilled care is available 24 hours a day. Prescribed by a physician, it is for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists.
- **Intermediate Nursing Care** - Intermediate care is less specialized than skilled nursing care and often involves more personal service. It is for people in stable condition who require daily, but not 24-hour, nursing supervision. It is ordered by a physician and supervised by registered nurses.
- **Custodial care** (also called personal care) - Custodial care is usually given by people without medical skills. It is less intensive than skilled or intermediate care. This type of care helps a person perform activities of daily living (such as bathing, eating, and dressing).

LTC services may be provided by one or a combination of the following:

- Family Members
- Home Health Care Agencies (HHC)
- Area Agencies on Aging (AAA)
- Adult Day Care
- Senior Centers
- Nursing Homes
- Assisted Living or Residential Care Facilities

Who Will Need LTC?

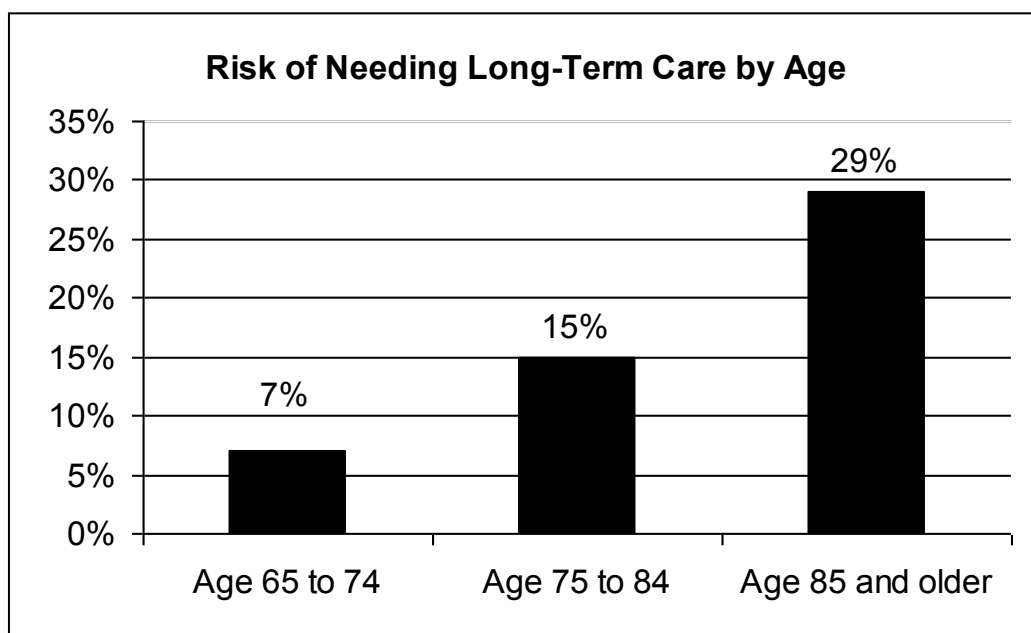
Most seniors will need **some** level of LTC at some point in their life (especially those living into their 80's).

Over 40% of Americans receiving LTC are ages 18-65

Most LTC is given informally by spouses and family members, with additional help given by friends, and/or neighbors. It is getting more difficult for family members to provide LTC because:

- More women, the typical caregivers, are working outside the home.
- Family size is smaller, and members do not always live nearby.
- A spouse is usually less able to provide care due to age and/or physical condition, and adult children have families and other obligations.

Hospital stays to recuperate from an illness or surgery are shorter due to the limits of Medicare and insurance policies that limit payments to hospitals to cover **only skilled care**. After short stays for treatment or surgery, patients are often moved to nursing homes to recuperate.



Common factors for predicting the need for Nursing Home Care are:

- **Age**

The longer you live, the more likely you are to need nursing home care. Due to better health care and a more stable and healthy diet Americans are living longer.

Life Expectancy in America between 1900 and 2000

1900 the average life expectancy was 40.75 years

1950 the average life expectancy was 65.45 years

2000 the average life expectancy was 74.5 years

An increase of 33.75 years from 1900 to 2000

- **Gender**

Women are more likely to need nursing home care, since they usually live longer than men. Approximately 85% of nursing home residents are women.

Average Life Expectancy in America by gender

	Men	Women
1900	40 years	41.5 years
1950	63 years	67.5 years
2000	71.5 years	77.5 years

- **Marital Status**

Elderly widows and widowers are 5 times more likely to enter a nursing home than are elderly married individuals.

Marital Status for Americans 65 and older between 1900-1990

	Men	Women
1900	65% Married 29% Widowed	34% Married 61% Widowed
1990	75% Married 14% Widowed	39% Married 50% Widowed

- **Health**

Family health history, individual health, and lifestyle factors influence the need for nursing home care.

PAYING FOR LONG TERM CARE

SECTION 37

How Much Does LTC Cost?

Long Term Care can be expensive. Costs depend on the amount and type of care needed and the facility. In 20 years, costs are expected to triple due to inflation. In Indiana, private pay rates in NHs have increased by 6.6% a year over the last 10 years. Costs vary by area and by provider (NH, HHC, etc.).

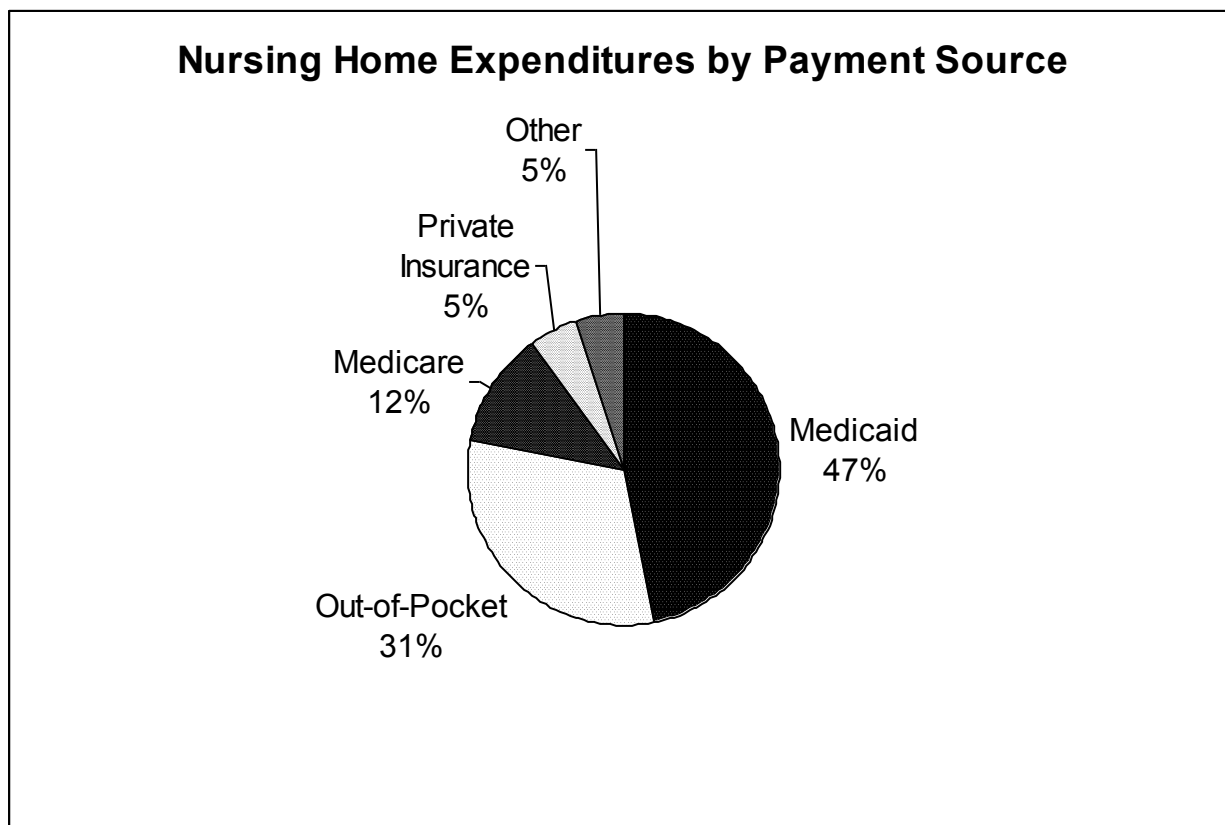
In 2008, the average national cost of . . .

- **Nursing Home** \$60,000 per year, approximately \$1,154 per week.
- **Home Health Care** Estimated Costs: HHC nurse - 5 visits/week for a year = \$28,000+. Currently 50% of those receiving home health care require 2-3 visits/week; 20% receive more than 3 visits/week; 30% receive 1 visit/week.
- **Adult Day Care Costs:** \$160 - \$240+/week
- **Assisted Living:** \$22,500 per year

By comparison, in 2000, the median household income for persons age 65 and over was \$23,048, which barely covers the cost of one year at an assisted living facility and covers **less than half the cost of one year in a nursing home.**

WHO PAYS FOR LTC?

Medicaid and Out-of-Pocket sources account for 78% of payments for nursing home expenses.



Out-of-pocket expenses may be paid from:

- Personal accounts
- Pensions
- Savings
- Investments
- Family assistance
- Contributions from children or relatives
- Associations, donors, other private funds
- Reverse Mortgages & Annuities

Who Pays for LTC - Your Family

Much LTC assistance is provided by informal, unpaid caregivers. In 1998, nearly one out of four American adults reported providing some form of informal LTC services. These caregivers are usually family members or friends who may provide a variety of services to assist their relatives or neighbors, from paying bills and preparing meals to helping them bathe or dress.

Caregivers provide assistance for a variety of reasons, including:

- The person being cared for does not require skilled professional services.
- The person being cared for cannot afford skilled professional services.
- The person being cared for does not want to be cared for by strangers.

Providing informal care, however, can take a significant toll on the caregiver. Many caregivers juggle their care giving responsibilities with other family or work responsibilities:

- over 60% informal caregivers are between the ages of 18 and 49
- more than two-thirds are married, indicating that many caregivers are probably raising their own children
- more than half are employed full-time
- another 12% are employed part-time.

These competing responsibilities can add to the emotional strain and financial burden of providing informal LTC services.

To ease the burdens of care giving, the federal government through the Older Americans Act and many states have created caregiver support programs. These programs typically provide counseling, information, and respite care to informal caregivers.

Fewer informal caregivers available

The responsibility of caring for an elderly individual traditionally fell to the person's adult children (typically to their adult daughters). Today, however, adult children often do not live near their parents, making such informal care giving arrangements difficult or impossible. In addition, women are increasingly working outside of the home, giving them little time to care for an elderly parent. Because fewer families can rely on informal caregivers, demand for home health aides and other professional care providers is increasing.

Services available to assist you and your family include

- Adult Day Care
- Case Management
- Chore Services
- Friendly Visitors and Senior Companions
- Home-delivered Meals (also called Meals-on-Wheels)
- Home Health and Personal Care Services
- Homemaker Services
- Hospice
- Personal Emergency Response Systems
- Respite Care
- Transportation Services

To find more information contact your local SHIP site, Area Agency on Aging, and/or Senior Services.

Who Pays for LTC - Self-Pay

If you have considerable investment assets and income, you may consider paying for your long term care needs as they arise or save for future long term care services. These assets should be invested to ensure growth that will keep up with the rising costs of long term care. As it is unknown when long term care is needed, it is difficult to determine when investing should begin.

Self-insuring is not the same as insurance. It does not provide the short-term protection that an insurance policy does. Insurance protects you from the possible risk of needing long term care before adequate funds are accrued.

Self-Pay Opportunities to Consider:

- You can retain full use of funds if not used for long term care.
- It works if you make the conscious choice years in advance of need.
- You have more choice and control over care.
- You don't have to worry about qualifying for LTC insurance.

Self-Pay Issues to Consider:

- It is unknown when/if the need for long term care will arise, and for how long.
- Amount saved may be insufficient to cover long term care costs.
- You need to be aware of rules of how and when funds can be accessed.
- You cannot control the rate of return.
- You need to start early to ensure enough time for funds to grow.
- You need to be disciplined and have discretionary income and assets to afford setting aside funds.
- Funds are tied up that you could use for other things.
- Self-insurance usually requires larger monthly amounts than traditional insurance.

Who Pays for LTC - Special Purpose Loans

There are many loans available known as deferred payment loans (DPL), property tax deferrals, or split loans. These low interest loans are available to those with low to moderate income.

Local agencies offer DPLs, which provide a one-time, lump-sum payment to be used for home repair or improvements. The types of improvements are usually specified and include improvements such as installation of ramps, grab bars and rails. These loans cannot be used to finance long term care, but they may allow you to remain independent and stay in your home longer. Interest is low and repayment does not occur until you no longer live in the home.

Contact your local SHIP site, Area Agency on Aging, or Senior Services for more information about Special Purpose Loans.

Special Purpose Loans Issues to Consider:

- The loan cannot be used to finance long term care needs.
- If you move into a nursing home, the loan payment comes due. This may negatively affect your long term care finances.

Who Pays for LTC - Medicare

Skilled Nursing Facility Care

Medicare provides some nursing home coverage, but this coverage is restricted to short-term nursing home stays after discharge from a hospital. Thus, this benefit is limited to post-acute care. The Skilled Nursing Facility (SNF) benefit was originally enacted to extend hospital care for patients recovering from an acute illness, but who could be more economically served in a skilled nursing facility.

For each benefit period, Medicare provides limited payment for skilled nursing home care as follows:

- Medicare pays for 100% of eligible charges for the first 20 days
- You make a daily co-payment for days 21-100. Medicare pays the balance of costs, if any.
- **Medicare payments end after 100 days.**

Most people do not require 100 days of skilled care in a nursing facility. Generally, after a couple of weeks of skilled care, they have stabilized and require only custodial care. In most cases, Medicare pays for less than three weeks of skilled care.

Medicare will only pay for daily skilled nursing care or rehabilitative services under very limited circumstances:

- Your physician has decided that you need daily skilled care.
- Your care begins within 30 days of a hospital stay of at least three (3) days for the same condition (about 50% of the people who need nursing home care do not first require care in a hospital).
- The beneficiary receives care only in a Medicare-certified skilled nursing facility and must be placed in a Medicare-certified bed.

Note: Not all nursing homes are Medicare-certified.

Home Health Care

The Medicare home health benefit covers the following services when certain circumstances are met:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and effectively by a licensed nurse.

Intermittent or part-time means skilled nursing and home health aide services furnished any number of days per week, as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

- Home health aide services on a part-time or intermittent basis. Medicare does not cover home health aide services unless skilled care such as nursing care is also being provided.
- Physical therapy, speech-language therapy and occupational therapy as long as the service is certified by a physician.
- Medical social services to assist with social and emotional concerns related to illness.
- Certain medical supplies, such as wound dressings, but not prescription drugs or biologicals.
- Durable medical equipment, such as a wheelchair or walker.

The following services are not covered:

- 24-hour a day care at home
- Meals delivered to the home
- Homemaker services such as shopping, cleaning and laundry
- Personal care services, such as bathing, eating or dressing

If you meet all of the conditions described, then **Medicare pays the full cost of all covered home health visits.** For **durable medical equipment, Medicare pays 80 percent of the approved amount** for Medicare-covered medical equipment.

All of the following criteria must be met to receive the home health care benefit:

- Your physician determines that home care is needed and devises a plan for your care at home.
- You require at least one of the following medically-necessary types of care: intermittent skilled nursing care, physical therapy or speech-language therapy, or a continuing need for occupational therapy.
- You are homebound (unable to move outside the home without assistance). To be homebound means that leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or attend religious services.
- Home care is provided by a Medicare-certified home health care agency.

Medicare Supplemental Insurance

Medicare Supplemental Insurance policies (Medigap) are health insurance policies sold by private companies to fill in some of the gaps in Medicare coverage. Examples of some gaps in Medicare coverage include:

- **Deductibles** – The amount you pay for Medicare-approved expenses before Medicare starts to pay.
- **Coinsurance** – The part of each Medicare-approved amount that you must pay after you have paid the deductible.
- **Non-Covered Services** – Not all services are paid for by Medicare. You pay for these services.

Medicare supplemental insurance policies were **designed to cover certain gaps** in Medicare. If you have a Medicare supplemental policy or Medicare supplemental coverage through a Medicare Advantage Plan, you may not have to pay the Medicare co-payment for skilled nursing home care when you have an approved Medicare stay. However, these **supplemental policies do not provide payment for any of the custodial or personal care coverage that Medicare does not cover.**

Who Pays for LTC - Medicaid

Medicaid is the government program covering most Nursing Home costs. Medicaid is the largest payer for nursing home care. Medicaid spent \$80 billion dollars on long term care in 2001, of which \$43 billion was for nursing home care. Medicaid is intended for low-income persons who need financial assistance for their health care. Most persons entering a nursing home use their own money first to pay for their care. In fact, over 90% of the elderly, without LTC insurance, use up their resources within 1 year after entering a NH. After “spending down” their income and assets, they may qualify for Medicaid.

Medicaid pays less than the actual charges of nursing homes. This represents an operating loss to them and is an important factor in their withdrawal from the Medicaid program. The result is that many of those nursing homes that do accept Medicaid now have waiting lists. (See Navigation Guide 4, Section O - Assistance for Low-income Persons, information on Medicaid eligibility, exempt vs. non-exempt assets, transferring of assets, and spousal impoverishment provisions.)

Spousal Impoverishment Protection Law

In the event that your spouse no longer lives at home due to poor health and **enters a nursing home**, (does not apply to home health care) the Spousal Impoverishment Protection Law protects you from losing all of your income and assets to pay for your spouse’s care in the nursing home.

Income

- **Personal Income** - Income in the name of each spouse remains his or hers, including income from assets that are in each spouse’s name only. The spouse at home may keep all of his/her income.
- **Jointly Owned Income** - Income from assets owned by both spouses is counted by Medicaid as jointly owned income. Jointly owned income is divided in half with each spouse getting a half. The spouse in the nursing home must use his/her income to pay for his/her care, but he/she may keep **\$52** a month for personal needs.

After the income is split, if the income of the spouse at home is less than the maximum allowable per month, he/she may keep part of the nursing home spouse's income in order to bring the at-home spouse's income up to at least the maximum. If the spouse at home has very high living expenses, they may apply for an increase in their allowable income level.

Assets

Most assets are considered by Medicaid as **joint assets** between husband and wife, regardless of in whose name the assets are placed.

The spouse at home may keep **one-half** of all countable assets up to a total of **\$109,560**, with a minimum of at least **\$21,912**.

The home is not counted as an asset when the applicant, spouse, or dependent children live there. Countable assets include checking and savings accounts, CD's, stocks, bonds, mutual funds, revocable trusts, cash values of life insurance policies, and IRA's.

Caution: Transferring of assets to qualify for Medicaid may cause a delay in receiving Medicaid's help in paying for nursing home costs.

For more information call **SHIP** at 1-800-452-4800, your local Office of the Department of Family Resources (administers Medicaid), your attorney, or the Senior Law Project Office in your area. (Listed in your Telephone Reference Book).

Medicaid Estate Planning

In order to qualify for Medicaid, you must first spend down your assets and use the proceeds to pay for long term care before Medicaid begins to pay. Spend down means liquidating assets.

Some people reduce their assets by gifting them to family members or others, or set up irrevocable trusts instead of using the assets to pay for care. Medicaid planning is the legal practice of rearranging finances so that Medicaid pays for nursing home care, while preserving the assets through change of ownership. However, in most cases Medicaid does not pay for home care or assisted living, and once on Medicaid an individual does **not have control over assets or where care is received**.

Medicaid “**look-back**” **rules apply** when assets are transferred for less than fair market value. When an individual applies for Medicaid -

For transactions made **before February 8, 2006**:

- Medicaid looks back 3 years from the date of application (5 years for trusts), to see whether any assets were transferred **for less than fair market value**.

If it is determined that a less than fair market value transfer has taken place, the applicant will not be eligible for Medicaid for a specific time period based upon the dollar amount of the transfer. After this penalty period, the applicant may re-apply for Medicaid. In circumstances where things may look suspicious, Medicaid may go back farther than normal look-back period.

For specific guidelines contact Medicaid through your local Department of Family Resources. Area phone numbers and/or internet addresses may be obtained by calling **SHIP at: 1-800-452-4800**. A qualified Elder Law attorney should be consulted when considering this option.

Medicaid Estate Planning Issues to Consider:

- This option is risky because of the look-back rules.
- You lose control of your assets.
- Transferring assets may affect your eligibility for Medicaid.
- Relying on Medicaid may limit access to care and choice of care.
- **Does not protect income.**

Who Pay for LTC - Veterans Benefits

The Veterans Administration (VA) provides an extensive array of long term care to veterans. Nearly 65,000 veterans will receive long term care this year through inpatient programs of VA or State Veterans Homes. More than 90% of VA's medical centers also provide outpatient long term care programs.

The VA provides institutional long term care to veterans through

- VA Nursing Homes,
- Community Nursing Homes,
- State Veteran Homes, and
- Domiciliary Care.

Services offered in both inpatient and outpatient settings include

- Hospice Care,
- Respite Care, and
- Geriatric Evaluation and Management (GEM).

Other outpatient long term care services provided by the VA include

- Home Based Primary Care,
- Community Home Health Care,
- Adult Day Health Care, and
- Homemaker/Home Health Aide Services.

VA also provides assistance to some veterans through the Community Residential Care Program.

Who is eligible for Nursing Home Care?

A veteran. . .

- who has a service-connected disability rating of 70% or more.

- who is rated 60% service-connected and is unemployable or has an official rating of “permanent and totally” disabled.
- with a combined disability rating of 70% or more.
- whose service-connected disability is clinically determined to require nursing home care.
- Non-service-connected veterans and those officially referred to as zero percent, non-compensable, service-connected veteran who require nursing home care for any non-service-connected disability and who meet income and asset criteria.
- If space and resources are available, other veterans on a case-by-case basis.

While many services are offered there are typically waiting lists for VA nursing homes, making access to veterans’ LTC services limited.

Service Centers in Indiana

The Indiana State Veterans Home is located in West Lafayette, Indiana. It provides nursing and domiciliary care for any Hoosier Veteran with at **least one day of wartime service**. To qualify you must have been a resident of Indiana for at least three years. The Home is open to **both wartime veterans and their spouses**. For more information write to the Home at: Indiana Veterans Home, 3851 N. River Road, West Lafayette, IN 47906. Or call (765) 463-1502.

The Richard L. Roudebush VA Medical Center located in Indianapolis offers LTC services, including Home Based Primary Care and Community Based Extended Care.

The VA Northern Indiana Health Care System, with locations in Fort Wayne and Marion, includes a 180 bed Nursing Home Care Unit. Services offered include a Dementia Unit, Home Based Primary Care, and Adult Day Health Care.

TRICARE For Life

TRICARE For Life (TFL) is a health insurance plan offered through the Department of Defense for retired military personnel and qualified family. **TFL is for all TRICARE beneficiaries who are eligible for Medicare because of disability, ESRD or age.** Like Medicare, TFL is designed to cover health care for injuries and illnesses. TFL will generally cover the same services that Medicare covers. Long term care is not a covered benefit through TFL.

TRICARE beneficiaries, upon **becoming entitled to Medicare Part B, will transfer from TRICARE to TRICARE For Life.** TFL will pay secondary to Medicare, when both programs cover the medical service.

To be eligible for TFL you must be one of the following:

- Medicare eligible uniformed service retirees, including retired Guard and Reservists;
- Medicare eligible family members, including widows/widowers; or
- Medicare eligible un-remarried former spouses, if they were eligible for TRICARE before age 65.

TFL pays -

- For services covered by both TRICARE and Medicare, TFL pays Medicare deductibles, coinsurance and co-payments, first three pints of blood each year
- 80% of costs at TRICARE network
 - for inpatient hospital care from day 151
 - skilled nursing facilities (SNF) from day 101
- 75% of costs at non-TRICARE network from day 151 for hospital, or day 101 for SNF.

For more information about veterans benefits please contact your Indiana Veterans County Service Officer, or the Indiana Department of Veterans Affairs office by phone (317) 232-3910, toll free call 1-800-400-4520; or online at www.in.gov/veteran.

Federal Long Term Care Insurance Program

The Federal Long Term Care Insurance Program (FLTCIP) provides an alternative to traditional LTC insurance to approximately 20 million people. The program is administered by the Office of Personnel Management.

Who is eligible to apply for FLTCIP?

- Most Federal and US Postal Service employees
- Active members of the uniformed services
- Tennessee Valley Authority (TVA) employees
- Washington D. C. government employees who were employed by the D. C. government prior to October 1, 1987
- Employees of the D. C. Courts
- Most Federal and US Postal Service annuitants
- Retired members of the uniformed services
- Individuals receiving compensation from the Department of Labor who were separated from the Federal service
- Federal and US Postal Service deferred annuitants
- Retired military reservists, including grey reservists
- Retired employees of the TVA
- Retired D. C. government employees who were first employed before October 1, 1987
- Retired employees of the D. C. Courts
- Surviving Spouses, receiving Federal survivor annuity, of Federal & Postal employees or annuitants; D. C. government employees or annuitants who were first employed before October 1, 1987; or D. C. Courts employees or annuitants
- Qualified relatives:
 - Current spouses of the above listed employees and annuitants
 - Surviving spouses of members and retired members of the uniformed services
 - Adult children- including natural, adopted, and stepchildren of living employees
 - Parents, Parents-in-law, and stepparents of living employees

You must be **18 years old** in order to apply. You will also have to answer questions about your health, and you may have your medical records reviewed and have an interview with a nurse. **There is no guarantee of approval.**

The FLTCIP offers four pre-packaged plans. You may chose one of these plans or customize you own plan by mixing and matching available benefits.

Pre-Packages Plans:

Facilities 100

- Covered Services: Nursing Homes, Assisted Living Facilities, Hospice Facilities, and Respite Service (in a facility).
- Daily Benefit Amount: \$100
- Benefit Period: 3 years
- Maximum Lifetime Benefit: \$109,500
- Waiting Period: 90 Days
- Inflation Protection: choice of automatic compound inflation protection, or option for future purchase.

Comprehensive 100

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount, Benefit Period, Maximum Lifetime Benefit, Waiting Period and Inflation Protection: same as Facilities 100.

Comprehensive 150:

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount: \$150
- Benefit Period: 5 years
- Maximum Lifetime Benefit: \$273,750
- Waiting Period: 90 days
- Inflation Protection: same as Facilities 100.

Comprehensive 150+

- Covered Services; Everything in Facilities 100 plus Home Care, Adult Day Care, Hospice Care (at home), Respite Service (at home).
- Daily Benefit Amount: \$150
- Unlimited Benefit Period
- Maximum Lifetime Benefit: Unlimited
- Waiting Period and Inflation Protection: same as Facilities 100.

The FLTCIP does not cover the following:

- Illness, treatment or medical condition as a result of your participation in a felony, riot, or insurrection; your attempted suicide; or intentional self-inflicted injuries.
- Care or treatment of alcoholism or drug addiction.
- Care or treatment received in government facility, unless authorized by law.
- Care received while in a hospital.
- Any services covered by Medicare, except for deductible, coinsurance, or co-pay.
- Services or supplies you are not obligated to pay in the absence of insurance.
- Services provided by family members.

For more information you can go online at www.ltcfeds.com and order an Information Kit with application, or call 1-800-LTC-FEDS (1-800-582-3337).

Advantages of the FLTCIP:

- The Federal Program reimburses on the actual cost of care, not at “usual, customary, and reasonable” rates.
- No Mental/Nervous Exclusion.
- No War Exclusion.
- International Coverage.
- Generous Informal Care Benefit.

**PRIVATE
TRADITIONAL
PLANS**

**SECTION
4L4**

PRIVATE LONG TERM CARE INSURANCE

Long-term care insurance is a relatively new type of private insurance coverage designed to protect against the potentially catastrophic costs of LTC. It helps pay for LTC expenses up to a pre-set amount. You select this amount when purchasing a policy. Typically, LTC insurance pays for care in a wide variety of settings including facility care, home care, and community-based care, although some people purchase more limited coverage that focuses only on one type of care setting.

In some respects, LTC insurance is similar to automobile or homeowner's insurance – it is bought in advance and you hope it is never used. Long term care insurance is there to pay for the catastrophic expenses associated with an unanticipated need in case it should occur. It provides peace of mind and financial protection.

- LTC insurance policies usually cover nursing home care and may include coverage for other LTC services.
- Approximately 60 companies now offer LTC policies in Indiana.
- LTC insurance is **meant to provide coverage for the most catastrophic expense**. The main expense is room and board and custodial care in a nursing home. (LTC insurance may **NOT** cover all of an individual's LTC expenses.

Indiana's definition of LTC insurance:

“An insurance policy providing coverage for **at least 12 consecutive months** for each covered person on an expense incurred, indemnity, prepaid, or other basis for 1 or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care wing of a hospital.

WHO SHOULD BUY LTC INSURANCE?

Buying a LTC policy should not cause a financial hardship or greatly alter one's lifestyle. For some, a LTC policy is an affordable and attractive form of insurance. For others, the cost may outweigh the benefits. Emotional, financial, and physical needs as well as your lifestyle are factors that must be addressed when considering a LTC policy.

It is always a good idea to check your current health care coverage for LTC benefits. Check individual health care plans, retirement and/or group health plans, and veteran's benefits, etc. You may not need additional LTC insurance.

COUNSELORS NOTE:

Often clients ask about LTC price comparisons before they have determined a need for an LTC policy. No price is a good price for a policy that does not match their financial situation or their LTC needs.

SOME COMMON REASONS FOR BUYING LTC INSURANCE ARE:

- **Asset protection.** If your total assets, (generally excluding your home and one auto) are valued at more than \$30,000.
- **To maintain your independence.** Depending upon the type of care that you may need, having an LTC policy may allow you to stay in your own home or move to a facility of your choice.
- **Family considerations.** Your spouse or other family members may not be able physically or financially to provide you with long term care. Even if they are able, you may not want them to face this responsibility.
- **Age at application.** Generally, the younger you are when purchasing an LTC policy, the less you will pay in monthly premiums.

To help you decide if buying an LTC policy would be right for you, use SHIP's "**Long Term Care Insurance Self-Assessment Guide**". (See Section L-5) This guide will help you evaluate your current situation (financial and factors such as age, gender, health, family participation) and determine what type of policy and options may best suit your needs.

Who Should Not Purchase LTC Insurance?

You should not purchase an LTC policy if you have or are:

- **Low Income:**
If your only source of income is a minimum Social Security Benefit or Supplemental Security Income (SSI). You can barely buy food, medicine, or basic needs such as clothing and household items.
- **Few Assets:**
You have no IRA's, cash value in life insurance, or others assets that can be converted to cash.
- **Poor Health:**
If you have existing health problems, such as Alzheimer's or Parkinson's disease, or you require assistance to bathe, dress, eat, or perform other activities of daily living, you will not be able to purchase an LTC policy.
- **Age 84+**
Very few companies sell LTC policies to those over age 84.

Who Sells Long Term Care Insurance?

- Private insurance companies sell individual coverage through company agents, independent agents, and direct mail.
- Some companies sell group coverage through senior citizen organizations, fraternal societies, business associations, and other groups.
- Some employers now offer LTC policies to their employees, their employee's parents, and to their retirees.
- You can also buy LTC benefits as part of an individual life insurance policy. Under this arrangement, a certain percentage of the policy's death benefit is paid when the policyholder requires LTC.

Indiana Standards for LTC Insurance

All LTC policies sold in Indiana after 1993 (Policies issued before January 1, 1993, operated under less strict standards) **must** meet the following standards:

- A policy cannot require a higher level of care to be paid by the policy before it would begin paying for a lower level of care.

Ex: If in a policy it is stated that the policy pays for all levels of care, then it cannot require that skilled care to be given before it pays for intermediate care.

- Prior hospitalization cannot be required as a condition for the policy to pay benefits. For Home Health Care benefits, prior Nursing Home Care cannot be required as a condition for the policy to pay. (Over half of all persons admitted to nursing homes are **not** hospitalized first.)
- A pre-existing condition waiting period cannot be longer than **6 months**.
- LTC insurance policies must be either **guaranteed renewable** or **noncancellable** (this language is found on the front page of the policy).
- An **inflation protection** feature **must be offered** to each applicant at the time of purchasing a policy. The insurance company chooses the type of inflation protection offered; you either accept or reject this option.
- After a policy is purchased, **Alzheimer's disease may not be excluded**.
- An agent or company must give you an **Outline of Coverage** (a policy summary), and a **Shopper's Guide for LTC Insurance**.

- **“Free Look”** If you return an LTC policy **for any reason within 30 days** (beginning the day that you actually receive your policy), you must be given a full refund of your premium.
- When coverage under a **group LTC** policy is about to terminate, the insurance company **must** provide covered individuals (who have been insured under the group policy for a minimum of 6 months) with an option to continue or convert their coverage. You do not have to prove that you are insurable (healthy) for the new coverage.
- Agents who sell LTC insurance must complete 8 hours of initial training. Every 2 years, they must complete an additional 5 hours of continuing education in LTC insurance (effective 12/31/96).

Policy Features in LTC Insurance

There are **no standardized LTC** policies as there are for Medicare supplement insurance. Many combinations of benefits and coverage are available. You must first determine the types and amounts of benefits you want, consider any acceptable limitations, then shop around for a policy that matches these interests.

Read the policy carefully and **don't assume** all services are covered.

LTC Coverage may include:

- **Nursing Home Care**

Unless otherwise stated in the policy, nursing home coverage usually means the policy will pay for all 3 levels of care; skilled, intermediate, and custodial.

- **Home Health Care**

Home health care coverage varies on the types of care that are covered. Some policies cover only skilled nursing care, while others may cover services of home health aides and provide assistance with custodial care. Still other policies may cover home visit services such as cleaning, cooking, and running errands. The policy will state what services will be covered.

- **Combination Nursing Home and Home Health Care.**

Some policies combine nursing home care and home health care. Policies of this type will state what services are covered and where these services are to be provided.

- **Community Care**

These policies cover a variety of services. Policies that include home health and community care benefits must cover adult day care. **Adult Day Care** is a program for 6 or more persons providing social & health related services during the day in a community group setting.

- **Alternative Care**

Alternative care policy options can cover care or services that are not specified in the policy, but are provided if agreed to by the insurance company, the insured person, and their physician. The care must be appropriate. Alternative care benefits are provided instead of normal policy benefits, are usually more desirable to the individual, and are less costly to the insurance company (ex: using an adult family home instead of a nursing home).

Policy Benefits and Limitations

Daily Benefit

The daily benefit is dollar amount the plan for care per day. It is usually paid out in **one of 3 ways**:

- **Indemnity**

Many LTC policies are “indemnity” policies that pay a **fixed amount** for each day of received care.

Ex: A policy that pays an \$150/day benefit, means the policy pays \$150 for each day of care, regardless of the actual cost of care. You are responsible for the remainder.

- **Percentage**

Some policies pay a percentage of the actual cost of services.

Ex: A 75% of the per diem (daily) charge benefit means that if the actual daily charge is \$150, the policy pays 75%, or \$112.50 per day. You are responsible for the remainder.

- **Up to Amount**

Some policies pay **up to a specified dollar amount** to cover the **actual charges** for services received.

Ex: An up to \$150/day benefit means the policy pays the actual charge, up to a maximum of \$150/day. If the actual charge is \$145/day, the policy pays \$145/day. If the actual charge is \$170/day, the policy pays \$150/day.

How the daily benefit is selected

- **For Nursing Home Care:** Insurance companies will offer a choice of daily benefits, usually from \$50 to \$250 a day for care. Before you select a daily benefit level, it is important that you know the cost of facilities in your area.
- **For Home Health Care:** The daily benefit for Home Health Care is usually **one-half** of that for nursing home care. Some policies pay the actual costs of care up to the daily benefit amount of your policy.
- **For Alternate Facility Care:** Policies may pay a lower daily benefit for residential care or assisted living services.

Insurance policies usually pay only after claims have been submitted. You will usually pay 1st, and then you will be reimbursed by the company.

Maximum Benefit

When buying a policy, you will be asked to choose a maximum benefit either **how long** you want the benefit to last, or **how much** you want the total dollar amount of benefits to be.

- **In time** - Benefits can last from one year to a lifetime in length. Policies pay until the specified amount of time has been reached.
- **In dollars** - You can choose policies with no maximum dollar amount, or for set amounts, for example; \$30,000, \$50,000, etc.

In some policies, the home health care benefit period coverage may be shorter than for nursing home coverage. **Read the policy for details!** Some policies limit the benefit period **by limiting the number of consecutive days they will pay**. This could result in your reaching the policy time limits before reaching the policy's maximum amount benefits.

Also, look at how the policy pays if you have a repeat stay in a nursing home. Some policies require you to be out of a facility for a certain period of time before you can receive benefits for a second stay. The longer or larger the maximum benefit, the more the premium will cost.

How Much Coverage Should I buy?

It's hard to predict future needs. You should choose a policy that has the **highest maximum benefits** that you can **comfortably afford**. Keep in mind, that one-half of all nursing home stays are **6 months or less** in length, because most people receive short term rehabilitation services. The other half of stays are for an **average** length of **2.8** years.

Inflation Protection

Inflation protection provides a way to cushion you from the full effects of future increases in long term care costs (i.e. NH, HHC). This can be important, because nursing home costs are predicted to rise a minimum of 5% each year due to inflation.

For example, a nursing home cost of \$150/day:

2003	2008	2013	2018
\$150/day	\$191/day	\$244/day	\$312/day

Inflation protection can be one of the most important additions you can make to a LTC policy, but depending upon whether you select simple or compound interest, an inflation protection feature may **significantly increase the policy's premium**.

In Indiana, insurance companies **must offer** the option of inflation protection. If you decline this option, you **must sign** a statement saying that you do not want the inflation protection provision.

A company may offer 3 kinds of inflation protection

- **Additional Coverage** - Every few years you could increase your daily benefit (at the price for your current age). Buying additional coverage this way **can raise the policy premium rapidly**, with the result being that you may find the additional protection unaffordable. If the additional coverage is **declined** when it is first offered, some companies may not allow future purchases of additional coverage.

- **Automatic Benefit Increases** - Under this option, you will have automatic benefit increases on the daily benefit by a **fixed percentage of not less than 5%**. Increases may be by either simple or compound interest, and must continue throughout the life of the policy. (Some older policies may stop the automatic benefit increase when you reach age 80 or 85.)
- **A Percentage of the Actual Or Reasonable Charges** - This inflation protection pays a percentage of whatever the actual or reasonable daily charges. For example: If today's actual cost of care is \$100/day, a 75% policy would pay \$75/day.

Waiver of Premium

A waiver of premium **usually only occurs when you are in a nursing home** and are receiving benefits from a LTC policy. Under this benefit, **during** your stay you are not required to pay the premiums for the policy. It **does not usually apply** when you are receiving home health care benefits.

Some policies:

- Waive the premium as soon as the first benefit payment is made. (You do not pay policy premiums or for benefits)
- Require a 60 or 90 day wait for the waiver. (Policy pays for benefits, you pay policy premiums)
- Require a 60 or 90 day wait before the policy begins to pay for benefits, **and** before the waiver of premium. (You pay the premiums and for any benefit) This is known as meeting the elimination period). (See p. 20 in the LTC Shopper's Guide)

If you pay LTC premiums advance, (3-month, 6-month, etc.) and your policy starts paying premiums under the waiver of premiums provision, the insuring company is not required to repay your advance premiums. When you return home your premiums will be taken from your advance payment balance, then you resume paying the policy premiums.

Nonforfeiture Benefit

If you cancel your LTC policy, the **nonforfeiture benefit** returns to you what you have invested in the policy. Without this provision, your loss could be substantial, especially if you drop the policy after 10 or 20 years, and never used any of the policy's benefits. A nonforfeiture benefit significantly increases the cost of the policy.

Non-forfeiture benefits may be offered in the form of a **reduced paid-up** policy, in which part of the benefits of the policy are still payable, even after you drop the policy.

A few companies offers a **return of premium** option in which they return all or part of the total premiums paid if a person drops a policy after a certain number of years.

Restoration of Benefits

The restoration of benefits provision in a LTC policy means that if the policyholder remains "off-claim" for a specific period of time (often 6 months) after a covered illness or confinement, the full amount of the policy benefits is once again available to be used by the person.

Ex: You own a LTC policy with maximum benefits of \$50,000. You are admitted to a nursing home for 3 months during which time you receive \$6,000 in benefits from the policy. Your total remaining benefit is now \$44,000.

You return home and remain there for 1 year (off-claim). Upon returning to the nursing home, **a policy with restoration of benefits** renews the policy benefits, and you again have \$50,000 available in benefits.

Due to the risk the company takes when including the restoration of benefits provision, premiums are usually higher with this option in a policy.

Policy Limitations: Gatekeepers

All LTC policies use "**gatekeeper**" provisions, that define what conditions must be met before you receive policy benefits. Gatekeepers **limit** the number of eligible claims which helps companies control their losses.

Gatekeepers are often subtle and hard to identify because, unlike policy exclusions, gatekeepers are not listed or labeled separately nor clearly. In the policy, look for “if” and “when” statements.

Questions to Ask about Gatekeepers

- Where, or from whom, must the person receive care?
- What level of care is eligible for benefits to be paid?
- Who must authorize the care?
- What must occur for care to begin?
- Must the person be disabled for benefits to be paid?
- How many days or visits must be satisfied before benefits begin?

Pre-Existing Conditions

Are you eligible to buy a policy? Remember, insurance companies “**underwrite**” their coverage. This means they will look at your health before they will issue you a policy. Companies prefer to sell to persons who are healthy.

Many companies will sell a policy to people who have relatively minor health problems, but will not cover them for those conditions for a set period of time. This is known as a **pre-existing condition waiting period**.

Indiana residents who purchase new LTC policies to replace an original LTC policy, will have the pre-existing condition waiting period in the **new** policy **waived** for any similar benefits (as long as a similar waiting period was satisfied under the original policy).

Elimination Period

When do benefits begin? With most policies, benefits will not begin the first day that you enter a NH or use home health care. LTC policies come with an **elimination period** (also called a deductible or waiting period). The elimination period is the amount of time you must be receiving care, and paying for that care, before the policy will begin to pay benefits. Elimination periods vary from company to company. Usually, **the shorter waiting time** for benefits to begin, **the higher you pay** in premiums. The Elimination Period can be no longer than 180 days.

Definitions and Exclusions

What services are covered, and **where** the services are to be provided will be stated in the policy. Does the policy cover “**assisted living**”, which is a residential living arrangement that provides **individualized personal care and health services** for people who require assistance with activities of daily living.

Activities of daily living (ADLs). Policies with this benefit trigger require that you are unable to perform a certain number of ADLs, before the policy begins to pay.

The main activities of daily living may include:

Bathing

Mobility

Maintaining Continence

Dressing

Using the toilet

Eating

Bathing and dressing are usually the first 2 ADL skills an elderly person is unable to perform. Read the definitions section of the policy to see which ADLs are used as benefit triggers

Who authorizes the care?

In the past, most insurance companies required authorization from a doctor for care to be given. Now a “**case manager**”, hired by the insurance company, usually makes the decision. These individuals take into account your medical history, social situation, and your family history, and normally work with a physician to develop a treatment plan.

The least restrictive policies allow care that is provided by state licensed NHs and HHC agencies. Check the policy carefully for restrictions on choosing providers.

Be sure to see whether the policy states what it means by the “**inability to perform**” a particular activity. Some policies clearly state they mean failure to feed or to bathe yourself, others leave it up to interpretation. Some terms to look for and understand in a policy include "hands-on", "continual one-to-one", "supervisory", or "directional" assistance.

Cognitive impairment. With this benefit trigger, you may qualify for benefits if you are unable to pass certain tests assessing your mental function, and if you have a condition such as Alzheimer’s disease.

You must follow the procedures outlined in the policy for obtaining case manager approval, or obtaining benefits or claims for services may be denied.

What is not covered?

All LTC policies include a section that lists conditions under which the policy will not pay. **Typical exclusions** in a policy are:

- Mental or nervous disorders, other than Alzheimer's.
- Alcoholism and drug addiction.
- Treatment needed due to acts of war or attempted suicide.
- Treatment already paid for by the government (Medicare, Medicaid, or VA).
- Services provided by a family member.

Benefit Triggers

"Benefit triggers" are another type of gatekeeper requirement that answers the question, "What has to happen before the policy will begin to pay benefits?" In a policy, these requirements are usually discussed in sections called "**eligibility for benefits**", "**qualifying for benefits**", or "**benefit conditions**."

There is a wide variation among policies regarding benefit triggers. Some policies may have more than one. Some policies may have different benefit triggers for Home Health Care than they do for Nursing Home care. Pay careful attention to the benefit triggers when reading a policy.

Typical benefit trigger terms to look for:

- **Medically necessary.** Some policies require a doctor's statement that a procedure is medically necessary.
- **Injury or sickness.** This benefit trigger usually applies when the insurance company determines that you are sick or injured enough to receive benefits.

What Do LTC Policies Cost?

A LTC policy can be expensive. Paying premiums should not cause you economic hardships now or in the future.

The Main Factors that Affect Price Are:

- **Age** - The younger you are when you purchase a LTC policy (“issue age”) the lower the premiums. Your premiums may increase over time due to loss-ratios of the insuring company, but premiums will not go up due to “attained age”.
- **Amount of daily & maximum benefits purchased** - The larger the daily benefit amount and the longer the benefit period, the higher your premiums.

Other options that generally raise the cost of an LTC policy include **inflation protection, nonforfeiture of benefits, and home health care.**

A portion of the cost of long term care premiums may be off-set by **tax deductions**. See the Consumer Information Bulletin (LTC Policy Tax Information, in the Section L1, Reference Materials for details on how you may qualify for State and Federal tax breaks. Please read the information carefully as not all policies qualify for these programs.

Can Rates Be Raised in the Future?

This answer depends on the **type of renewability** in the policy. LTC policies sold in Indiana must be either Guaranteed Renewable or Noncancellable. Most policies are Guaranteed Renewable. (See Navigation Guide 4, Section N - General Insurance for more information)

Buy a New Plan or Upgrade Existing Coverage?

Before you buy a new policy, make sure it's better than the one you already have. Your agent may have switched companies and now wants you to buy a new policy, or you may have heard about a new policy offering.

Some important points to consider:

- Carefully consider any changes and the reasons why you want to change.

- Make sure your new application is accepted before you cancel the old policy.
- If you cancel your policy in the middle of its term, most companies will not return any premiums unless you have a “return of premiums” option that **includes** cancellation of a policy.
- Switching may be appropriate if you have an older policy which requires a prior hospital stay or requires you to receive skilled care before it will pay for custodial care.
- If you bought a policy and now want to add options or change parts of the policy, ask your insurance company about adding enhancements to the policy in the form of **policy riders**, such as inflation protection, etc. It might be cheaper to keep the policy that you have and improve it rather than to buy a new one.

**INDIANA LONG
TERM CARE
INSURANCE
PARTNERSHIP
PROGRAM
(ILTCIP)**

**SECTION
5L**

The Indiana Long Term Care Insurance Partnership Program

These policies are commonly referred to as **Indiana Partnership LTC Policies**. All LTC insurance provides some level of asset protection in that the policy pays for LTC instead of you paying out of your assets. Once the benefits of a **traditional LTC insurance** policy are used up and you apply for Medicaid, you must meet the Medicaid requirements for assets and income to be eligible for Medicaid benefits unless you have purchased a policy with unlimited benefits.

If you had purchased an **ILTCIP policy**, you would only need to spend-down those assets which are above the amount of insurance benefits used (unless you had a **total asset** protection policy) and meet the income provisions to qualify for Medicaid.

Origin, Structure, and Objectives

- The Indiana Partnership Long Term Care Insurance Program (ILTCIP) **provides an incentive and a means to protect assets** for Hoosiers who are considering their potential LTC needs.
- The ILTCIP is a **Partnership between Indiana's Medicaid program and private insurance companies**.
- In 1993 ILTCIP policies became available to Indiana Residents, and may be purchased from private companies that are approved to sell ILTCIP policies in Indiana.
- **On the front of the policy it must be stated that it is a ILTCIP policy.**
- A primary goal of the Program is to prevent Hoosier seniors from becoming impoverished due to catastrophic costs of LTC.
- The Indiana Long Term Care Insurance Program is administered by the **Indiana Family and Social Services Administration**, in conjunction with the Indiana Department of Insurance.

Components of the ILTCIP

Quality Assurance

ILTCIP insurance policies participating in the Program must meet special requirements established in regulation, containing important consumer protection features. These features are in addition to the standards adopted by the Department of Insurance for all LTC insurance.

Asset Protection

By purchasing a qualifying policy or certificate, you will be able to protect all (total asset protection) or part, (dollar for dollar) of your assets in the event that you apply for Medicaid to pay for your long term care.

Protected assets will be considered exempt by Medicaid in determining your eligibility for Medicaid benefits. **Your income is not protected.**

- If you have a **dollar for dollar policy**, you will be able to protect assets equal to the amount of benefits paid for the actual cost of your long term care (up to the limits of your policy).
- To have **total asset protection**, you must purchase a policy at the **state required minimum level** for the year in which you purchase the policy. The minimum levels are listed below.

The original effective date of your policy	The State Set minimum dollar amount for total asset protection
2006	\$206,844
2007	\$217,186
2008	\$228,045
2009	\$239,447
2010	\$251,419

What Assets are Protected?

The ILTCIP policy allows you to protect all assets that Medicaid would normally consider should you apply for Medicaid, including such assets as **stocks, cash, bonds, other real property, and the fair market value of your primary home (if you have no spouse)**. These assets are **not usually exempt**, and must normally be expended before the person would be eligible for Medicaid.

Remember, under the “Spousal Impoverishment” provision, the community spouse is allowed to keep a portion of the couple’s non-exempt assets, while qualifying the NH spouse for Medicaid. Under this provision, the protection of assets no longer applies once the NH spouse dies or if the community spouse enters a nursing home.

Features and Benefits of ILTCIP Policies

Policies must cover room & board and nursing care in licensed Nursing Homes.

Companies **must offer** you the option of purchasing an **Integrated Policy**. If you choose to purchase only an **LTC Facility Policy**, you **must sign a statement of rejection** of the integrated policy.

- **Integrated Policies must include home and community care benefits.** Maximum benefits must be available for either NH care or home and community care (comprehensive coverage). Home and community care coverage **must include** home health nursing, home health aide, attendant care, respite care, and adult day care. These benefits must be provided through **a case management system**. This system will develop a plan of care and then link you with the appropriate provider agencies.
- **LTC Facility Policies** cover only care received in a LTC facility. **Coverage does not include home and community care benefits** (after one year, a comprehensive rider may be added).

Indiana Long Term Care Insurance Partnership Policies **must include Inflation Protection**.

You are guaranteed the right to reinstate a lapsed ILTCIP policy within a specific time period, (as stated in your policy) from the date of lapsing the policy, if the lapse was due to a cognitive impairment. This time period should be stated in the policy.

If your coverage is about to lapse, you must be offered (at least once) the option of a policy with a lesser maximum benefit at a reduced premium.

Maximum Benefits must be available in **Dollars**.

Benefits must be coordinated with other public and private insurance benefits, extending the length of time benefits are available. This means ILTCIP policies pay last, except with Medicaid (the payer of last resort).

Benefit triggers are **standardized** for all participating policies. Insurers are required to use **Activities of Daily Living and Cognitive Impairment as criteria** for when the policy would start paying benefits.

Agents selling participating policies must complete an **additional 7 hours of training on ILTCIP** before marketing any ILTCIP policies (a total of 15 hours of training WITH 8 hrs in LTC insurance and 7 hrs on ILTCIP.)

A one year policy must be offered by all insurers in the Program.

Companies **must offer a minimum daily benefit**, which is 75% of the average daily private pay rate in Indiana (State determines this figure). The minimum daily benefit for policies sold in 2010 is **\$115/day**. Many companies are selling their one year ILTCIP policy with a maximum benefit of \$36,000.

Examples of How the Asset Protection Benefit Works

The amount of maximum benefits that are purchased in a policy is based on the amount of assets to protect. The protected amount should be at least equal to the cost of 1 year of coverage in a nursing home, or approximately \$36,500.

Example # 1

Mr. Matthews purchases a Partnership policy with **maximum benefits of \$60,000** (about **2 years** of care in a NH).

Mr. Matthews enters a NH and stays for 2 years, and his policy pays the full \$60,000 in benefits, **protecting \$60,000 of Mr. Matthews' assets**, but he must stay longer in the NH.

He may now apply for Medicaid coverage, since \$61,500 of his assets are now protected from Medicaid in determining his eligibility (\$60,000 from ILTCIP policy + \$1,500 allowed by Medicaid). His income will pay for the cost of his care and Medicaid will pay his remaining medical expenses.

\$60,000 - Policy paid out = the amount of assets protected.
\$61,500 = Mr. M's assets + Medicaid \$1,500 asset allowance.

Mr. Matthews has no remaining assets he must expend before being eligible for Medicaid.

Example # 2

Mr. Thomas has \$100,000 in assets. He is only interested in protecting \$60,000, so he purchases a Partnership policy with maximum benefits of \$60,000.

Mr. Thomas enters a NH and stays for 2 years. The **policy has paid the full \$60,000 in benefits**. Assume, however that Mr. T remains in the NH. If he applied for Medicaid at this point, he would be denied eligibility.

\$100,000 - total amount of Mr. Thomas' assets.
\$60,000 - Policy paid out = the amount of assets protected.

Mr. Thomas has \$40,000 in assets remaining. He must expend \$38,500 towards his medical expenses (\$40,000 - \$1,500 = \$38,500) to meet the Medicaid asset requirement. His income would also continue to pay for the cost of his care. Medicaid would pay the rest of his medical expenses.

What if you have a ILTCIP Policy and Move Out of State?

If you move from Indiana to another state, the insurance **benefits** of ILTCIP policy **would be paid** regardless of where you are living (some policies may have exclusions for care outside the United States).

The **Medicaid Asset Protection** offered in Indiana Partnership policies applies only to Indiana's Medicaid program.

For example: You are receiving LTC benefits from your ILTCIP policy while living in another state, your policy has paid the maximum allowable benefits, and you apply for Medicaid in that state.

Your **assets will not be protected*** unless you must move back to Indiana and make application to Indiana's Medicaid program.

The only exception would be if you are living in a state having a reciprocal agreement with Indiana Medicaid. Asset protection honored under this reciprocal agreement is only on a dollar-for-dollar basis. For a current list of states participating in a reciprocal agreement see following website:

<http://www.dehpg.net/ltcpartnership/StateReciprocity.aspx>

The Future of the ILTCIP Program

The Program has been established in State statute and **cannot be discontinued without legislative action**. Should the Program be discontinued in the future, for whatever reason, **the state will stand behind the asset protection benefit** of all qualifying policies sold to that point, for the remainder of the lives of those who purchased these policies.

For further information or if you have questions, contact SHIP 1-800-452-4800 or **The ILTCIP Program at:**

1-866-234-4582

or

www.in.gov/fssa/iltcp

PRIVATE PAY OPTIONS

67-20-1CFS

Private Options Available to Pay for Long Term Care

There are other options, besides Long Term Care insurance, government programs, and family that you can chose from to finance your long term care expenses. However, not everyone will qualify or have the means for all options. It will be important to assess your physical and economic circumstances in choosing the options that best suit your long term care needs.

Private Long Term Care Financing Options

Life Insurance	Long Term Care Annuities	Trusts	Home Equity	Assisted Living
Accelerated Death Benefits	Deferred	Medicaid Disability Trusts	Reverse Mortgage	Continuing Care Retirement Community
Life Settlements	Immediate	Charitable Trusts	Reverse Annuity Mortgage	
Viatical Settlements			Sell Back	
Single Premium Life/LTC			Leaseback	

Life Insurance Policy Accelerated Death Benefits

Life insurance policies sold in Indiana after 1987 may have an **accelerated death benefits provision**. An accelerated death benefit (ADB) allows cash advances against your death benefit while you are still alive. You may obtain a portion of the “**face value**”, (the amount that the policy pays at the death of the insured) plus accumulated earnings, (if applicable) **prior to your death**. Accelerated death benefits are usually offered in the form of **policy riders** and can may be added to existing policies at little or no cost.

ADB policies will specify what conditions must occur in order to activate the accelerated benefits. Typical triggers are:

- **Terminal Illness** - You are diagnosed by one or more doctors that death is expected within a specified period. This is the **most common** type sold. Most of these policies pay out in a lump sum payment.
- **Dread Disease** - You become ill from a specific condition or disease named in the policy (ex: stroke, life threatening cancer) which, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span. Some policies cover major organ transplants. Most of these policies pay out in a lump sum payment.
- **Confinement to a nursing home** - You are **permanently** confined to a nursing home with permanent function loss - incapable of performing certain activities of daily living (ADLs). The life expectancy is usually less than 6 months; although, some companies use less than 12 months to live. Currently only about 3% of products include this provision.
- **Long Term Care** - You may be covered under the policy for Home Health Care expenses as well as for confinement in a LTC facility. LTC is the second most common type of accelerated death benefit. Most of these policies pay out periodically (usually monthly).

The use of funds, received from the ADB, is restricted to covering the expenses resulting from the benefit trigger.

Normally you do not have to pay an additional premium for the accelerated death benefit product (in Indiana). Most companies in Indiana use a “**discounted method**”. When benefits are paid out, you receive the percentage of benefits stated in the policy; however, the company keeps the amount of interest they would have earned had the acceleration of benefits not occurred. So, you pay for the accelerated benefit either way.

The amount of your ADB is based on the provisions of your insurance policy and the conditions triggering the benefit. Usually the ADB payment is **capped at 50% of the death benefit** - there are some policies that will allow the full amount to be used. For ADB policies that cover long term care the monthly benefit is typically equal to 2% of the face value for nursing home care and 1% for home care.

For example, if the face value is \$50,000, the monthly benefits would be \$1,000 for nursing home care and \$500 for home care.

The amount of the ADB is subtracted from the amount payable to beneficiaries upon your death. The more ADB used for your care the smaller death benefit will be left for your heirs.

ADB's paid to **terminally or chronically ill people are not subject to federal income tax**. Check with your tax advisor to verify the status of state income tax on ADB's. There is the possibility that an ADB would affect your eligibility for Medicaid. Check with your lawyer or case worker for verification of your situation.

ADB Opportunities To Consider:

- An ADB included at the time you purchase a life insurance policy may help you later because you might not qualify for a long term care policy at an older age.
- You can add an ADB rider to an existing policy at little or no cost.
- From one insurance policy you can benefit two ways - paying for your long term needs, and leaving a death benefit to your heirs.

ADB Issues To Consider:

- ADB policy benefits are usually more limited than typical long term care insurance. These policies can only be used if you have a terminal illness, dreaded disease, need nursing home care permanently, or cannot perform ADL's.
- The face value amount may not be large enough. In this case the ADB payment will not be enough to pay for your long term care needs.
- You must continue to own your policy and pay the premiums. An ADB policy can lapse if premiums are not paid.
- Inflation protection is not usually offered.
- If you need a lot of health care and use the ADB, there may be little if any death benefit for your heirs.
- If you are on Medicaid or plan to apply in the near future, this option may affect your Medicaid eligibility.

Life Settlements

Life Settlements (also known as Senior Settlements, Elder Settlements, or High Net Worth Settlements) give you the option to adjust to changes in your health goals or life circumstances by selling your life insurance policy, for the present value of the policy. This is usually done when the original reason why you bought the policy no longer exists (i.e. a divorce, or your heirs do not need the funds) or the insurance premium may not be affordable after retirement. The money from the sale of your policy can be used to pay for your long term care.

To be eligible for this you must meet an **age requirement**: 74 years of age for women and 70 years for men. Some companies will make an exception and may purchase a life insurance policy from a 65 year old, if the life expectancy is determined to be 12 years or less. **You do not have to be in poor health or terminally ill to take advantage of a Life Settlement.**

What types of policies can be sold?

- Term Life Insurance
- Whole Life Insurance
- Universal Life Insurance
- Individual Policies
- Group Policies
- Policies held in an irrevocable life insurance trust
- Buy-sell agreements
- “Key-Man” Policies - policies taken out on individual whose death would have a significant financial impact on the company or organization.

The use of the proceeds is unrestricted and can be used for a variety of expenses. You can purchase a long term care insurance policy, or you can use the funds to cover long term care expenses, if you are denied for a long term care insurance policy.

There are tax consequences for this option

- The difference between the settlement payment and the cash surrender value of the policy is taxed as capital gains.
- The difference between the total premiums paid and the cash surrender value is taxed as ordinary income.

If you are considering this option, you should discuss your situation with a tax professional before selling your policy.

Life Settlement Opportunities to Consider:

- You can use the money from the sale of your life insurance policy to pay for your long term care needs.
- You do not have to be in poor health to take advantage of this option. You may qualify for long term care insurance and use the proceeds from the sale to pay for the insurance.
- If you do not need long term care, you can leave something to your heirs.

Life Settlement Issues to Consider:

- The money you get from selling your life insurance policy is taxable. Check with a tax professional before selling your policy.
- Depending on the amount you receive, you may not have enough money to pay for all of your long term care needs.

Viatical Settlements

If you have a terminal illness, you may consider selling your life insurance policy to a viatical settlement company in exchange for a percentage of the policy's face value. The viatical company will become the sole beneficiary of the policy and responsible for paying the premiums.

The difference between a Life Settlement and a Viatical Settlement is a matter of time and health. In general a Viatical Settlement is the sale of a policy by someone who has a life expectancy of two years or less (exception: some companies will purchase a policy if the life expectancy is four years), whereas a Life Settlement is an option for someone with a life expectancy of more than two years, but less than thirteen years. There are different tax consequences as well. Viatical Settlements are usually federal income tax free, but Life settlements are subject to tax.

Each company sets its own rules for determining which life insurance policies it will buy. For example, most viatical companies will require that:

- You have owned your policy for at least two years.
- Your policy has a large value, most companies have a minimum policy size such as \$100,000 or \$250,000.
- Your current beneficiary sign a release or waiver.
- Your policy be issued from a well-known insurance company.
- You sign a release allowing the company access to your medical records.

The National Association of Insurance Commissioners (NAIC) has developed the Viatical Settlements Model act governing the licensing and regulation of viatical companies. After December 1998, in order to act as a viatical settlement provider in Indiana, an individual must be licensed by the Indiana Department of Insurance.

NAIC Suggested Guidelines for Viatical Payments

Life Expectancy	% of Death Benefit Paid
1-6 months	80%
6-12 months	70%
12-18 months	65%
18-24 months	60%
Over 24 months	50%

Other factor influencing the amount of the payments are:

- Insurer's rating—a lower rating may lower the viatical payment.
- Waiver of premium - if the company does not have to pay a premium on the policy, than the payment may be higher.
- Case Diversification of Viatical Company - you may get a better offer from a company with a diversified consumer base.

Because the decision to sell your life insurance policy is a very complex matter, you should **consult your tax advisor**. Generally speaking, if you sell your policy to a viatical settlement company, the proceeds are federal tax free when you have a life expectancy of less than two years and you live in a state that requires licensing. However, you may still owe state tax on the proceeds.

If you are considering a Viatical Settlement on your life insurance policy, take care not to make hasty decisions. These consumer guidelines should be considered before any action is taken:

- **Avoid companies that use a hard seller high pressure approach.** You have the right for unconditional rescission of the contract 5 days after receiving payment, or 30 days after the contract is executed, whichever is longer.
- **Shop around.** Review offers from several companies to make sure offers are competitive, and be aware of the prevailing discount rates.

- **Ask about privacy policy.** During the negotiations the broker should respect your privacy. Companies unrelated to the negotiations should not be contacting you.
- **Insure the funds are available.** Insist that the company set up an escrow account with a reputable independent institution before the company sends the offer papers for your signature. An escrow account will ensure that the funds are available to cover the offer.
- **Check with the Indiana Department of Insurance** to verify the company is licensed in the State of Indiana, and check on any complaints against the company.

Viatical Settlement Issues to Consider:

- If you live longer than expected, your funds may be exhausted.
- The settlement may be insufficient for the type and amount of long term care needed. This type of care is for those who are terminally ill, not just in need of long term care.
- Your survivors will not receive any proceeds from the policy. If leaving an inheritance is important to you, this may not be a good option.
- You may not qualify for this option as more than 50% of applicants are declined.
- The settlement may affect your eligibility for Medicaid.

You also may want to contact the following organizations for more information:

- **Affording Care** - 429 E 52nd St, Unit 4-G New York City, NY 10022-6431
- **American Council of Life Insurance** - 1001 Pennsylvania Ave., N.W. Washington, DC 20004-2599
- **National Association of Insurance Commissioners** - 444 North Capitol St., N.W. Washington, DC 20001
- **National Association of People With AIDS** - 1413 K Street, N.W. Washington, DC 20005
- **National Viatical Association** - 7910 Woodmont Ave., Suite 1430, Bethesda, MD 20814
- **North American Securities Administrators Assoc.** - 555 New Jersey Ave., N.W. Washington, DC 20001
- **Viatical Association of America** - 1200 19th St., N.W. Suite 300 Washington, DC 20036

Single Premium Life/LTC Policies

Unlike traditional Long Term Care (LTC) policies that require premiums to be paid for life or until the care is needed, Single Premium Life/LTC Policies are funded through a **lump sum payment**. You may receive at least double the amount of your deposit for long term care expenses.

You can use the following sources of funds for your lump sum payment:

- Cash
- Certificates of deposit (CD's)
- Non-qualified and qualified annuities
- Cash value from a life insurance policy
- Money market accounts
- IRAs and Keogh plans

The source of the premium payment will affect the issue age. If the premium is paid from qualified annuities, IRAs or Keogh plans, an issue age of 59.5 or higher may be required. The usual maximum issue age is usually 80 years. **A joint policy can be issued if both spouses fall within certain age parameters.**

Minimum deposits can be in the \$10,000-\$20,000 range, but for a meaningful benefit the deposit should be around the \$100,000 range, for a couple at 60 years of age. If you are willing to self-insure a portion of long term care expenses, or have other ways of financing your long term care, a smaller deposit can be made.

The lump sum deposit purchases a death benefit and depending on the amount used for long term care your heirs may receive a death benefit. The longer you have the policy and do not file a claim, the more money you will have for your future long term care. If long term care is needed immediately, the policy could pay as much as four years of benefits at 2% per month.

Single Premium Life/LTC Opportunities to Consider:

- You may have access to twice the amount of your deposit for long term care needs.
- This type of insurance policy pays a death benefit to your heirs.
- No monthly premiums.
- You may be able to move money from your life insurance policy without paying tax penalties. For more information about tax issues, check with tax professional.

Single Premium Life/LTC Issues to Consider:

- To keep pace with rising long term cost, you may need to purchase additional coverage, or buy a rider for inflation protection and make additional payments.
- You would need to make a substantial lump sum payment for the long term care benefit to be meaningful.
- Your policy may not cover your long term care needs as you get older. Make sure the policy will cover your current and future needs.

Long Term Care Annuities

An annuity is a series of regular payments over a specified and defined period of time. Annuities can help you pay for your long term care if you do not qualify for Long Term Care insurance due to age or health problems. There are two types of Long Term Care Annuities: deferred and immediate.

Deferred Annuity with long term care benefits:

This annuity is available for persons **up to age 85** and has seven broad health questions that most people can satisfy.

One example of this type of annuity consists of two funds. The first fund is for long term care expenses and grows at a high interest rate with a five year guarantee. It then grows at the current interest rate thereafter. The second fund grows at three percent guaranteed and is a regular cash fund.

The purpose of the separate long term care fund is to allow immediate use of funds for licensed long term care services. Otherwise, early withdrawals from a regular deferred annuity are limited and can be penalized. The amount of the monthly benefit is determined by dividing the long term care fund balance by 34.5. A lifetime rider may be available for an additional premium.

You may make annual withdrawals of 10% from the cash fund to pay for additional expenses under the long term care fund. **Withdrawals greater than 10% from the cash fund may be penalized.** If the long term care fund is not exhausted at the time of death, any remaining money in the cash fund will be passed on to the beneficiary.

Tax Rules

- Earnings on the money are tax deferred, however you may be taxed on the gain as withdrawals are made.
- These deferred annuities are non-tax qualified long term care policies. There may be a risk of being taxed on the money from the fund that is used to reimburse long term care expenses.
- A tax professional should be consulted.

Another type of annuity/long term care product would act as a standard deferred annuity with a long term care rider attached. This rider could be accessed after a six year waiting period through traditional activities of daily living (ADLs), and cognitive impairment benefit triggers. It would pay a monthly benefit based on a percentage of the amount that had accrued in the annuity portion but would not reduce the annuity portion of the contract.

The money from the long term care rider is considered taxable. As there is no medical underwriting required, this might be an option for someone who is uninsurable with traditional long term care insurance with a condition that might not require care for six or more years (early stages of Parkinson's for example).

Deferred Annuity Issues to Consider:

- The benefit may not adequately cover all long term care expenses. This may happen if long term care is needed before the annuity fund has grown or the long term care rider is available for access.
- Inflation protection is not included. You would need to put in enough money to accommodate inflation.
- You should consult a tax professional.

Immediate Annuity

Immediate annuities are available to people with **uninsurable health conditions or who may already be receiving long term care**, as well as those in good health. A single premium payment is converted to a monthly income stream guaranteed for a specified period of time. Most common time periods are:

- The life of the policyholder
- A minimum guaranteed period
- Life plus a minimum guarantee period
- A joint and survivor annuity option.

The annuity **pay out is based on age and gender**. With an annuity that is not medically underwritten and all things being equal (age, amount of annuity, etc.), as women tend to live longer than men, a man would receive a higher monthly payment than a woman. If the annuity is medically underwritten, a person with impaired health would receive a larger payout, due to a shortened life span. Medically underwritten annuities are not available in all states.

Immediate Annuity Issues to Consider:

- You must carefully plan for inflation in order to ensure that enough funds are available for your long term care needs.
- Income may be insufficient as the type and amount of long term care may be unknown.
- If your health condition does not reduce life expectancy, the annuity payments may not be any better for a medically underwritten annuity than for a regular annuity.
- The annuity can continue to pay to your beneficiaries after your death if an annuity with a minimum guarantee period is chosen, not a life only option.
- Tax treatment of immediate annuities is complicated. **A tax professional should be consulted.**

Trusts

A Trust is a legal arraignment by which one person (the grantor) transfers assets to another (the trustee) for the benefit of one or more third parties. The trustee holds the title to assets and manages them, acting in the best interest of the beneficiary or beneficiaries. Trusts may provide some options to fund long term care. Primary examples are Medicaid Disability Trusts and Charitable Remainder Trusts.

Medicaid Disability Trusts

This trust is the only type exempt from rules regarding trusts and Medicaid eligibility. All other irrevocable trusts currently created with the intent to transfer assets without spending down run the risk of being disqualified.

This trust is limited to disabled individuals.

There are two types of Medicaid Disability Trusts:

- **Trust for Disabled Persons Under Age 65.**

This can be established by a parent, grandparent or legal guardian. You may set up this trust to provide benefits to enhance the life of an individual who is qualified for public benefits. If Medicaid benefits are paid on behalf of the individual, any amount remaining in the trust at the time of death is recoverable by the state up to the amount of such benefits.

- **Pooled Trust Managed by a Non-Profit Association.**

This is also used to enhance the life of the disabled person while maintaining eligibility for Medicaid. It can be set up by a family member or legal guardian. Funds are pooled for investment, but a separate account must be maintained for each beneficiary. At the time of death the state must be reimbursed for the Medicaid benefits paid on behalf of the beneficiary from the funds remaining in their account. **This trust can be set up for a disabled person over 65 years old.**

The trusts must be properly drafted to effectively accomplish their goals. It is very important that an experienced attorney be consulted.

Medicaid Disability Trust Issues to Consider:

- **Limited to disabled individuals.**
- Medicaid benefits must be reimbursed upon the death of the beneficiary. Not all money in the trust will be sheltered.
- Check with your tax advisor concerning any tax issues.
- Trusts must be properly prepared drafted to effectively accomplish their goal. **You must seek competent legal counsel.**

Charitable Remainder Trusts

These trusts allow you to use your own assets for long term care with the added benefit of reducing taxes. This type of trust is limited to affluent people with specific types of assets that are gifted to a public charity at fair market value. You would receive tax deduction based on the market value of the gift.

Payments to you from the charity are also based on the fair market value. You may use these funds to cover long term care expenses while reducing taxes. Upon your death, the charity receives the balance of the trust.

Charitable Trust Issues to Consider:

- Few people have the assets for this type of trust.
- Payments may be insufficient to cover your long term care needs.
- Assets transferred to the trust are subject to a 60 month look back, which may make you ineligible for Medicaid.

Reverse Mortgage (Home Equity Conversion)

A Reverse Mortgage (RM) is a type of home equity loan that enables homeowners **age 62 and older** to convert some of the equity in their home into cash, and continue to own and live in the home. It operates similar to a traditional mortgage, but in reverse. Instead of paying the lender, the lender pays the home owner.

Because you would retain ownership of the home, **you would be responsible for taxes and repairs**. The loan is paid off by the sale of the property once you move out or die. You can never owe more than the home's value. If there is any equity left, it would go to your heirs.

You are required to be counseled before applying for a RM loan. The counselor's job is to educate you about reverse mortgages, to inform you of other alternatives available to you, and assist you in determining which RM plan is best for you. A list of FHA approved counselors is included in the Long Term Care Portfolio.

Several factors determine the amount borrowed:

- Your age
- Your life expectancy
- The equity in your home
- The location of your home
- The interest rate

The maximum loan amount ranges from 50-70% of the home's fair market value. There are **no income or credit qualifications**; however, the home must be completely or nearly paid off to qualify. Funds may be paid in a lump sum, monthly installments, a line of credit, or a combination of the three. **This money is non-taxable.** It does not count towards income or affect Social Security, Medicare, or Medicaid benefits as long as the payments are spent within the month they are received. The interest on RM payments is not tax deductible until the debt is paid.

There are three types of RMs: FHA–Insured; Lender-Insured; Uninsured.

FHA-Insured Reverse Mortgages

These loans are insured by the Federal Housing Administration (FHA). They are offered by banks, mortgages companies and other private-sector lenders. As they are insured, the **government is required to make the payments if the lender goes out of business**. The most widely available plan is the FHA's Government-insured Home Equity Conversion Mortgage (HECM) program. This RM plan accounts for around 90% of the total market. In order to qualify for this program, you must be 62 years of age and be living in a single-family home or condominium that is your principal residence.

Payment options offered:

- Monthly advances for a fixed term, or life
- A line of credit
- Monthly advance plus a line of credit

Quick Facts:

- Repayment is not due as long as you live in the home.
- With the line of credit option, you may withdraw funds as needed over time.
- Closing costs, mortgages insurance, and sometimes monthly servicing fees are required.
- Interest is at an adjustable rate. Interest rate changes do not affect the monthly payment, but do the rate at which the loan balance grows.

Pros of a FHA Insured RM

You can change the payment method at little cost.

Loan advances are guaranteed to continue even if the lender goes out of business.

Cons of a FHA Insured RM

You may receive smaller advances than lender insured plan's.

Loan costs may be greater than with uninsured plans.

Lender Insured Reverse Mortgage

Lender Insured RM offer monthly loan advances, or monthly loan advances with a line of credit, for as long as you live in your home. One example is the Federal National Mortgage Association's (FNMA, also known as Fannie Mae) Homekeeper plan. This plan may be available to people who have **homes that are more expensive, or those who need to borrow more money.**

Eligible home types include:

- Single-family Homes
- Condominiums
- Units in qualified planned unit developments
- Properties held in trust
- Qualified leasehold properties

Quick Facts:

- Interest rates may be fixed or adjustable.
- Additional loan costs can include a mortgage insurance premium, as well as other fees that you may be able to finance and include in the mortgage.

FNMA also offers a Homekeeper for Home Purchase plan. This plan allows you to obtain a Homekeeper RM in connection to the purchase of a new home-in a single transaction. This transaction would allow you to reduce out of pocket cash needed to buy a new home, eliminate any new monthly mortgage payment, and keep more of the sale proceeds from your older home to use for other expenses. You may want to use this plan if you wish to sell your home and move closer to family, move to warmer climates, or move to a home that provides greater accessibility.

Pros of a Lender-Insured RM

Loan amounts may be larger than those provided by FHA-Insured RM, and you may be allowed to mortgage less than the full value of your home. This process would allow you to preserve equity for your later use or to leave for your heirs.

Cons of a Lender-Insured RM

Loans may involve greater costs than FHA-Insured loans. Higher cost means the loan balance grows faster, leaving less equity over time.

Uninsured Reverse Mortgage

Uninsured RM are dramatically different from FHA and Lender-Insured RM. You have **only the strength of the lender to back whatever promises are made** as to payments and other terms. If your objective in seeking a RM is future income rather than a lump sum payment up front, a federally insured plan may be a better choice.

Quick Facts:

- Monthly advances are for a **fixed term only** - this is determined when you first take out the loan.
- The loan **balance is due when the loan advances stop**.
- Interest is usually set at a fixed rate, and no mortgage insurance is required.

Pros of an Uninsured RM

If you have a short-term but substantial cash need, this plan can provide a greater monthly advance than the other plans.

Cons of an Uninsured RM

You must pay back the loan by a specific date. It is important to have a source of repayment.

If you are unable to repay the loan, you may have to sell your home and move.

Consumer Tips When Looking at RMs:

- **One size doesn't fit all.** The amount of payment you receive and the real cost can vary from one plan to another.
- **Look at all options.** There are major differences among the plans.
- **Compare total costs.** The total annual loan costs (TALC) rate is the best way to compare the true total costs. The TALC rate declines over time, and can vary from one plan to another.
- **Credit lines are not equal.** The credit lines offered by different plans are not equal. The HECM credit line is the only one in which the remaining credit grows larger every month at no additional cost to you, providing the value of your home increases.
- **A RM is a non-recourse loan.** In other words, when seeking repayment the lender does not have recourse to anything but the house.

RM Issues to Consider:

- RM is a financial resource option if you do not qualify for Long Term Care Insurance.
- Funds can be used to purchase Long Term Care Insurance, or to pay for long term care needs.
- RMs provides cash flow if you are “house rich but cash poor”.
- Your heirs can retain the home by repaying the RM.
- Since your long term care needs are unknown, the loan may be insufficient.
- Loans do not adjust for inflation.
- Your home may need to be sold to pay for long term care needs in excess of the loan amount.
- If the loan contract does not provide **lifetime tenancy**, you may outlive the terms.
- **You are responsible for all taxes, insurance, repairs, and maintenance.** If the home falls into disrepair, repayment may be triggered.
- This may not be an option if you want to leave your home free and clear to your heirs.
- The costs of obtaining RM can be very high, and may have to be paid in cash.
- RM options are confusing and numerous.
- If you are already ill or have a shortened life expectancy, you may not receive the full benefit that a healthy person would receive.
- **Clarify with the lender how long you are allowed to stay away**

Reverse Mortgage Annuity

In a RM Annuity, part of the lump sum loan amount is used to purchase an annuity. Even if you sell or move from the home the annuity payments will continue. The loan must be paid off when you either die, sell, or move from the home. The annuity payments from the separately purchased annuity can continue.

Annuity payments **may be taxable and affect eligibility for SSI (Supplemental Security Income) and Medicaid.** Check with a lawyer and/or tax professional about your situation.

Additional charges based on increases in the value of the home during the term of the loan may be included if an equity participation option is chosen by the borrower in order to lower the interest rate.

Caution - the term “reverse annuity mortgage” is used to refer to RMs that are structured with a monthly income option. **You must be sure to fully understand the type of RM you are considering.** This is important in understanding the tax issues, loan repayment terms, and monthly payment promises.

Sell Home

One way of using your home to pay for long term care is to sell it. The proceeds can be invested to produce a continuous income, pay for long term care expense, or purchase a LTC insurance policy. This option may ideal if you are single, without heirs, or to a married couple wanting a lifestyle or location change. If you have the alternative of a less costly living arrangements, you may find this a viable option.

Issues to Consider:

- You may be uncomfortable selling a major asset.
- You would be unable to pass the family home to children as an inheritance.
- Proceeds may be insufficient to cover long term care expenses.
- Timing may be an issue. Market value may not be at its best.

Leaseback

A leaseback occurs when an investor purchases a home below market value and the investor agreed to rent the house to the seller on a long-term lease. With a leaseback you would no longer have to worry about maintenance or repairs to the home, or paying property taxes. The proceeds can be used as you desire, to finance long term care needs, or to purchase LTC insurance.

The investor is partially reimbursed for the long-term lease through the difference between the selling price and the higher fair market value. Long-term leases or even a life estate have an economic value that can be reflected in the sale price of the home.

Taxes and property maintenance is the responsibility of the investor. Possession goes to the investor once you no longer live in the home.

Leaseback Issues to Consider:

- This may be an option to keep the home in the family by allowing children to take the role of investor.
- You may have to pay taxes on the proceeds of the sale. Check with your tax advisor.
- This may affect your Medicaid status.
- If the property is neglected, you may find it difficult to live there, and you may not have the funds or authority to correct the situation.

Continuing Care Retirement Community

A Continuing Care Retirement Community (CCRC) provides full continuum of care in a variety of settings, allowing you to “age in place”. As your needs change, the services offered by the CCRC changes from independent living to assisted living, to nursing home care - all in the same location.

Usually you pay an entrance fee and monthly payments to the CCRC in exchange for housing and defined long term care services. Fees vary by the size of the unit, (studio, one-bedroom, two-bedroom, larger) and by the location. A recent survey reports that the average entrance fees for one and two-bedroom apartments range between \$59,000 and \$121,000. These fees are subject to increases as operation costs increase.

A percentage of the entrance fee is usually reimbursed to the residents or their estate when they move or die. Interest earned is not paid to you, the resident, although you may be responsible for paying income tax liability on the interest income.

The monthly service fee may increase as the amount of care increases. In many cases LTC insurance is incorporated in the monthly fee. The CCRC collects the benefit to provide care to you. Since the CCRC is planning on residents not needing care for a certain amount of time, in order to keep its fees reasonable, you must be relatively healthy to enter.

Types of CCRC Contracts

While similar in concept, contract provisions differ. It is important for you to review the contract carefully to determine the services included in the entrance and monthly fees. The contract should also state the conditions that allow for increases in monthly fees, as well as procedures for adjusting fees when living accommodations change.

Should you or your spouse move into a nursing facility, the contract should state how long the remaining spouse stays in the living quarters, and how long the living quarters will be maintained. If the contract includes a termination clause, term and procedures should be clearly stated. Contract review requires legal and financial assistance, consult your lawyer, financial planner, and/or tax advisor.

CCRC Contract Types

	All Inclusive	Fee for Service	Modified
Entrance Fee/ Monthly Payment	Covers housing and all LTC fees. Usually higher than other types of CCRC.	Housing, social and recreational services. Access to LTC services. Less expensive than All Inclusive.	Housing, social services and physical assistance included along with a specified amount of nursing home care.
Not Included/ Incremental	Medical services which are usually covered by Medicare or supplemental health insurance.	LTC and medical services are paid by the resident as required. None of services are pre-paid.	Additional LTC services offered for a fee.

Contact your local SHIP site, Area Agency on Aging, or Senior Services for information on CCRC in your area.

CCRC Opportunities to Consider:

- You may not need to worry about long term care needs depending on the CCRC.
- Entrance fee may be refundable at death, or when the independent living unit is occupied by a new resident.
- Monthly fees may be reduced if you have your own LTC insurance.

CCRC Issues to Consider:

- CCRC may provide little or no home care.
- May have to meet specific health requirements to qualify for entry.
- CCRC usually has preset conditions for when care is received.

- All-Inclusive Life Care Contract may not be available.
- Very important that you understand the terms of the contract.
- Cost of facilities may be out of reach for some.
- Campus lifestyle may not appeal to you.
- Check into the history of rate increases in the monthly fee. You may need to consider if you would be able to afford significant increases in the future.
- Need to consider what would happen if the CCRC were to go bankrupt.